STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35930 Based on observations, record review, and interviews with residents, staff, medical doctor, nurse practitioners, and law enforcement, the facility failed to protect a female (who was deemed an incompetent person by the North Carolina Clerk of Court) resident's (Resident #1), right to be free from sexual abuse by a cognitively impaired male resident (Resident #2). On 05/15/24 Resident #1 was naked from the waist down in her bed when Nursing Assistant (NA) #1 observed Resident #2 in Resident #1's bed with his face between Resident #1's legs. Resident #1 was incapable of giving consent for Resident #2 to touch her. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause trauma. Additionally, the facility failed to protect Resident #2 from resident to resident physical abuse. Example #2 was cited at a scope and severity of D. This deficient practice affected 2 of 4 residents reviewed for abuse. The findings included: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses which included, in part, dementia with other behavioral and psychotic disturbance, muscle weakness, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic pain syndrome, depression, anxiety disorder, muscular dystrophy, and bed confinement status. A review of the State of North Carolina Letters of Appointment Guardian of the Person document revealed Resident #1 was deemed an incompetent person before the Clerk of The General Court of Justice Superior Court Division on 07/27/23. A review of Resident #1's annual Minimum Data Set (MDS), dated [DATE], revealed that Resident #1 was severely cognitively impaired. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #1's Care Plan, last updated 02/07/24, revealed she exhibits or has the potential to demonstrate verbal and physical behaviors related to cognitive loss/dementia and indicated she preferred to wear facility gowns versus her own clothing and had tendencies to expose herself while lying in her bed without privacy precautions. The Care Plan indicated she had a Brief Interview for Mental Status (BIMS) score of 3 and noted it fluctuated at times. The Care Plan specified Resident #1 had impaired/decline in cognitive function or impaired thought processes related to vascular dementia and acute encephalopathy and exhibits or is at risk for alterations in functional mobility related to cerebrovascular vascular accident (stroke) with left-sided flaccid hemiplegia. The Care Plan indicated Resident #1 met Preadmission Screening and Resident Review (PASRR) II Level of determination secondary to serious mental illness. A review of Resident #1's quarterly MDS, dated [DATE], revealed that Resident #1 was cognitively intact, had the ability to make herself understood, had the ability to understand others, and had no behaviors. The MDS indicated that Resident #1 was dependent on staff for oral hygiene, toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbances, cognitive communication deficit, mental disorder not otherwise specified, depression, anxiety disorder, and muscle weakness. A review of Resident #2's quarterly MDS, dated [DATE], indicated that Resident #2 was moderately cognitively impaired with clear speech and the ability to make himself understood and to understand others. The MDS indicated Resident #2 had no behaviors and required the extensive assistance of one staff for bed mobility and transfers, had no impairment with his upper and lower extremities, and used a wheelchair as a mobility device. A review of Resident #2's Care Plan, last updated on 03/15/24, revealed Resident #2 had the tendency to exhibit sexually inappropriate behaviors related to cognitive loss and dementia (initiated on 01/11/23), and had impaired and/or declined cognitive function or impaired thought processes related to dementia. An interview was conducted with Resident #3 on 05/23/24 at 8:15 a.m. Resident #3 was assessed as severely cognitively impaired on 02/27/24. Resident #3 asked if this interview was about the incident involving her roommate (Resident #1) and Resident #2 that had occurred a few nights ago or the one a while back. When asked to explain, she said one weekend not too long ago (referring to the 05/11/24 incident), she said she had left her room and when she returned, she saw Resident #2 trying to get in the bed with Resident #1. She said she immediately left the room to find the nurse (Nurse # 1) and report him to her. Resident #3 said the nurse came to the room and threatened to call the law if he would not leave the room. Resident #3 said Resident #2 was always in her & Resident #1's room, day or night, because Resident #1 always wanted him to bring her a soda. She said as far as she knew, the two of them never had a sexual relationship but they did have a friendship and he spent a lot of time in their room bringing her sodas and talking to her. A review of Resident #2's Progress Notes revealed he had been discovered by Nurse #1 on 05/11/24 entering a female resident's room and attempting to get in the bed with her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Nurse #1 on 05/22/24 at 1:15 p.m. Nurse #1 indicated on Saturday, 05/11/24, around 1:00 p.m. - 2:00 p.m., Resident #3 was observed standing in the doorway to her and Resident #1's room and called for the nurse. Nurse #1 stated she went to the room and observed Resident #2 attempting to get into Resident #1's bed. Nurse #1 stated she had never known Resident #2 to display any inappropriate sexual behaviors with Resident #1 or any other resident. She explained that Resident #1 and Resident #2 have always had a friendship and he often brought her sodas; however, on that day, she observed Resident #2 to have placed his wheelchair beside Resident #1's bed and had one of his knees on the side of her bed as if he was trying to climb into the bed with her. Nurse #1 stated Resident #1 told her, he's not doing anything and that Resident #2 did not say anything. Nurse #1 stated she then removed Resident #2 from the room, returned him to his room, and put him into his bed. Nurse #1 explained she called the Director of Nursing (DON) to get the telephone number of the new Assistant Director of Nursing (ADON) who was their on-call admin that day. She further explained she informed the DON of the incident who instructed her to call the ADON. She did so and was told by the ADON to document the incident and because she had already removed Resident #2 from Resident #1's room, there had been no further instructions. An interview was conducted with the ADON on 05/22/24 at 1:50 p.m. The ADON explained she had received a phone call from Nurse #1 on 05/11/24 about Resident #2 attempting to get in bed with Resident #1. The ADON further explained, stating that because Nurse #1 had already removed Resident #2 from Resident #1's room and had placed him in his bed, she said she instructed the nurse to continue to monitor. The ADON stated she failed herself in that she had not asked the nurse if Resident #1 was in her bed at the time Resident #2 was attempting to get in the bed as she assumed he was just trying to get into the bed. When asked if this incident had been discussed with the Interdisciplinary Team during their Monday morning meeting, she indicated it may have been since it had been a change in Resident #2's condition, however she did not have any notes from that particular meeting. Review of the facility's Initial Allegation Report, completed by Nurse #3 on 05/15/24, revealed an allegation of resident abuse on 05/15/24. The facility became aware of this allegation on 05/15/24 at 4:30 a.m. The allegation stated that a male resident (Resident #2) was found in a female resident's (Resident #1) room and that the male resident was noted to be performing oral sex on the female resident. The report indicated the facility reported the incident to law enforcement on 05/15/24 and to the State agency on 05/15/24. The witness statement from NA #1 was reviewed. It read, .Patient [Resident #2] was addressed several times from getting in and out of bed. Patient was then placed up front to desk. Patient stated he was ready to go to bed. Patient was placed in bed. Patient was watched for 20 minutes and I started my rounds. I heard bell ringing and step into hall. I went to answer call light and saw [Resident #2] with his face between [Resident #1's] legs with her diaper off. Nurse was notified ASAP [as soon as possible]. Nurse responded ASAP. [Resident #1] stated that nothing happened. I saw [Resident #2] with his mouth on [Resident #1's] private part. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with NA #1 on 05/21/24 at 12:13 p.m. NA#1 confirmed she worked the 11:00 p. m. to 7:00 a.m. shift that began on 05/14/24 and ended on 05/15/24 and had been assigned to care for both Resident #1 and Resident #2 during her shift. NA #1 explained Resident #1 was alert and able to make her needs known and required the extensive assistance of staff to being fully dependent on staff for her care needs. She explained that Resident #1 frequently removed her adult diaper and hospital gown so to find her in a stage of undress was not unusual for her. NA #1 explained Resident #2 had never displayed inappropriate sexual behaviors and admitted that he was known for frequent masturbation, however that act was always performed when he was in his own room. She stated that she had never known Resident #2 to make inappropriate sexual remarks or display inappropriate sexual behaviors towards other residents or staff. NA #1 stated that the rooms of each resident, on the morning of the incident, were located on opposite sides of the same hall however not quite directly across from each other. NA #1 explained that Resident #2 had been up and down all night and had required frequent redirection that night, which had been unusual for him as he typically stayed in his bed, in his room, at night. NA #1 stated she was not sure what had been going on with Resident #2 that particular night, but because he had been restless, she had given him a shower and placed him at the nurses' station in his wheelchair. She explained that he sat at the nurses' station for a couple of hours while she continued to make rounds on her other residents. She stated she had noticed Medication Aide (MA) #1 had taken him back to his room because he had wanted to lie down and stated she continued making rounds. Around 3:30 a.m. - 4:00 a.m. (05/15/24), she noticed the call light for Resident #1's room had come on and she went to the room to respond to it. Upon arriving to the room, the door to the room was shut and she had not been able to open it fully as Resident #2's wheelchair was blocking the door from opening all the way. NA #1 explained she was able to push open the door enough so as to allow her head into the room and stated when she looked in, she noticed Resident #2's wheelchair was positioned near the foot of Resident #1's bed (with the wheelchair facing the head of Resident #1's bed), between the wall and the left side of Resident #1's bed however it blocked the door to the room fully opening. She stated she observed Resident #2's right foot on the floor and his left leg and upper torso was in the bed with Resident #1, with his face between Resident #1's legs and his mouth on Resident #1's vagina. She noted that he was dressed in a t-shirt and pajama bottoms while Resident #1 was observed in a hospital gown which had been pulled off one of her shoulders and the bed covers were pulled up to her chest but pulled away from the lower half of Resident #1's body leaving her exposed from the waist down. She stated Resident #1's adult diaper had been taken off and was noticed on the floor beside the bed. NA #1 indicated Resident #1's breasts were not exposed. NA #1 explained she and Resident #1 made eye contact but Resident #1 did not say anything at that time. She stated Resident #2 seemed unaware he was being observed. NA #1 stated she asked them, what are y'all doing? at which time Resident #2 became aware of her presence and looked at her but did not say anything. NA #1 stated she then took a step back, away from the doorway but still in sight of the residents, and immediately called for Nurse #4 who had been standing in an area by the front of the nurses' station. NA #1 stated Nurse #4 immediately came to the room. NA #1 heard Resident #1 tell the nurse that nothing happened. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The witness statement from Nurse #4 was reviewed. It read, [Resident #2] has made multiple attempts entering [Resident #2's] room. He was put to bed multiple times with himself transferring back the bed and attempting to enter her room again. He sat with us at the nurses' station for a while until he stated he was ready to lay down. After 20 minutes of no signs trying to get up again, me and the CNA [certified nursing assistant] [NA #1] was doing her rounds. She went into [Resident #2's] room to do care and found [Resident #1] with his head between her legs performing oral sex. She immediately informed me and resident [Resident #2] was removed from room. Unit Manager was called. DON [director of nursing] was called. Administrator was called with no answers. I then called [name of an Administrator from a sister facility who was assisting the facility while the facility's Administrator was out on leave] for further instructions. He directed me to call both resident's families and ask if they feel they are capable of making decisions. Placed [Resident #2] on 1:1 supervision, perform skin check on female resident. I got in contact with [Resident #2's] RP [responsible party], left a voicemail for [Resident #1's] RP to call the facility back at her earliest convenience. Got statements from all involved. Female stated nothing happened, male could not give coherent statement. An interview was conducted with Nurse #4 on 05/21/24 at 3:47 p.m. Nurse #4 confirmed she worked on 05/14/24 from 7:00 p.m. until 7:00 a.m. (05/15/24) and had been assigned to care for Resident #1 and Resident #2. She explained she had noticed Resident #2 was awake, in his wheelchair, and that he kept trying to enter Resident #1's room and that he had to be frequently redirected. She said this was abnormal behavior for him; around 12:30 a.m. - 1:00 a.m. (05/15/24), he had been brought to the nurses' station where he stayed for approximately an hour. She stated around 3:30 a.m., the resident started nodding off, so he was brought to his room, assisted back into his bed and that once he started to fall asleep, she left. The nurse said around 15 minutes later, NA #1 informed her that Resident #2 was in Resident #1's bed and stated she immediately went to the room but once there, she could not fully open the door as his wheelchair was blocking it from inside the room. Since he was already back in his wheelchair, she pushed open the door wide enough for her to shimmy her way in there and immediately removed him from the room. Because of what NA #1 had told her, she returned to Resident #1's room and performed a skin assessment which included her perineal area (the area between the anus and vulva in females) which did not reveal any signs of trauma. After that, Nurse #4 stated she began making phone calls to the administrative staff which included the Administrator, the DON and the Unit Manager. When she did not get an answer, Nurse #4 called the Administrator from a sister facility (who had been assisting their facility during the absence of the facility's Administrator) who instructed her on what the next steps would be to begin an investigation of the incident. She stated she called the Responsible Party (RP) for Resident #2 and spoke with her. She stated she then called the guardian of Resident #1 (as she is a ward of the State) and left a message for her to return the call. Nurse #4 stated the guardian returned her call while and explained that Resident #1 was not able to give consent for a sexual act. Nurse #4 stated after that, the Unit Manager (Nurse #2) had arrived and had been the one to call local law enforcement who came to the facility and interviewed the staff. Nurse #4 stated she provided the police officer a copy of the statements she had taken from Resident #1 and Resident #2. Nurse #4 stated Medication Aide (MA) #1 witnessed her conversations with the Resident #2's RP and with Resident #1's guardian. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with MA #1 on 05/22/24 at 8:49 a.m. MA #1 confirmed she worked on 05/14/24 from 7:00 p.m. until 7:00 a.m. She stated she had worked at the facility for as long as both residents had resided there and had never known Resident #2 to display any inappropriate sexual behaviors before. She also said it was the first time that she could recall seeing Resident #2 up in the middle of the night. MA #1 explained she had been charting at the desk at the nurses' station when she observed Resident #2 going into Resident #1's room, estimating the time to be before 4:00 a.m. but was unsure of the exact time. MA #1 further explained she took Resident #2 out of Resident #1's room and brought him to the nurses' station where he sat for approximately 15-20 minutes and then he was brought to his room. She stated after another 15-20 minutes or so, the call light for Resident #1's room came on, explaining it had been Resident #1's roommate (Resident #3) who had pressed the call light. MA #1 said she saw NA #1 go to the room to respond to the light and then heard NA #1 yell for Nurse #4 to go to the room. MA #1 said when NA #1 returned to the nurses' station, she described to her what she had witnessed in the room - that Resident #2 was in bed with Resident #1 and had his head between her legs. MA #1 clarified that she had not written a statement about the incident as she did not witness anything herself, however, she did witness the statements Nurse #4 had taken from the two resident's responsible parties. An interview was conducted with Resident #3 on 05/23/24 at 8:15 a.m. Resident #3 said the other night (referring to the 05/15/24 incident), Resident #2 probably would not have come into the room if Resident #1 had not invited him in. She said she was awake and although the curtain between the two beds was pulled and she could not see anything, she could hear the two of them whispering back and forth. Resident #3 said she could not really hear what they were whispering about, but she was adamant that Resident #1 never hollered out while Resident #2 was in the room. She said she pushed the call light button so someone would come and get him out of her room at that time of morning. An interview was conducted with Resident #1 on 05/21/24 at 11:10 a.m. She was observed sitting up in her bed and wearing a hospital gown. After introductions, Resident #1 asked, is this about [Resident #2]? and then, before any further conversation, Resident #1 said, I told him not to ever come back in here because he tried to come get in the bed with me. I had to hit him on the side of his head, and I stopped him from trying to get in bed with me. When asked if she had invited Resident #2 into her bed, she stated she had not and remarked that he had tried to go up under the covers and touch her leg and repeated what she had said moments before. Resident #1 then became focused on various body aches and pains and wanted to see her nurse and did not want to discuss the incident any further, therefore, the interview was stopped at this time. A second interview with Resident #1 was conducted on 05/21/24 at 1:42 p.m. during which she was more receptive to questions and conversation about the incident of 05/15/24. Resident #1 was adamant that Resident #2 did not sexually assault her and stated that he did try to touch her leg under her bed covers and wanted to talk with her however, she could not understand what he was saying and she had told him to get out of her room and to never come back. Resident #1 stated Resident #2 did not touch her vagina with his hands, mouth or tongue. She stated he would bring her red sodas and admitted he was not her friend nor was she afraid of him. Resident #1 acknowledged the fact that she prefers to wear hospital gowns and stated she frequently removes them because they are aggravating. She also said she has to wear an adult diaper however, the tabs come undone which is also aggravating, so she will take it off frequently. Resident #1 remarked that she did not want Resident #2 to get in trouble for trying to touch her and said, what's done is done. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Resident #2 was conducted on 05/21/24 at 1:59 p.m. He was observed sitting in his wheelchair assisting the Activities Director who had been assigned to stay with him during his 1 on 1 observation that day. Resident #2 admitted that he and Resident #1 were friends and that he would occasionally buy her a red soda and bring it to her in her room. When asked, Resident #2 stated he did recall the 05/15/24 incident. He explained when he was in Resident #1's room, she encouraged him to perform oral sex on her when she pulled the covers back and had her legs open. Resident #2 stated he did not have intercourse with her and said that she was so nice that he had wanted to treat her like a girlfriend. He also stated that Resident #1 did not tell him to stop or get out of the room and that she did not hit him. He stated after the incident, he was moved to another room on the other side of the facility and that Resident #1 had been moved to another facility. An interview was conducted with the Unit Manager (Nurse #2) on 05/22/24 at 9:11 a.m. She confirmed that she worked on 05/15/24 from 7:00 a.m. until 6:00 p.m. Nurse #2 stated she had been made aware of an incident involving Resident #1 and Resident #2 when Nurse #4 called her at home, prior to her arrival to the facility. She indicated that she had spoken with the Administrator from their sister facility who had given her instructions related to the investigation of this incident. She explained she had called the police around 7:00 a.m. and that they had come to the facility right away and interviewed staff, but she does not think they spoke with either resident. Nurse #2 further explained she had moved Resident #2 across the building to another room on 05/15/24 and that Resident #1 was moved to a private room close to the nurses' station on 05/16/24. Nurse #2 stated she had never known Resident #2 to exhibit any inappropriate sexual behaviors, but that he often bought sodas for Resident #1 as well as other residents. She stated she had never known Resident #1 to have inappropriate sexual behaviors but did recall a time in the past where she appeared to have a fond relationship with a male resident (who no longer resided in the facility). Nurse #2 explained Resident #1 did like to undress and would frequently remove her hospital gown and adult diaper. She said she talked with Resident #1 on the day of the incident and denied anything of a sexual nature had taken place with Resident #2; she said Resident #1 told her that she told him to get out of her room after he tried to get into her bed that morning. When asked about the difference in Resident #1's Brief Interview for Mental Status (BIMS) assessment scores, Nurse #2 stated she had been completing the Brief Interview for Mental Status (BIMS) assessments since the facility did not have a social worker on staff until recently. She confirmed she completed the 03/28/24 assessment on Resident #1 (which resulted in a score of 13) but had not done the January 2024 assessment (which had a score of 3). Nurse #2 explained that because of the discrepancy between the two assessment scores in such a relatively short period of time (as well as Resident #1's other varied BIMS scores), she had repeated the March assessment with a second nurse present and the score remained 13; she said she completed another BIMS assessment on Resident #1 on 05/15/24 and her score was 12. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A recreation of the room Resident #1 resided in on 05/15/24 was conducted on 05/23/24 at 8:00 a.m. with NA #1 who witnessed the incident of 05/15/24. Resident #1 had resided with Resident #3 in a semi-private room. Resident #1's bed had been the A bed, which was the bed closest to the door. The A bed remained empty, and the facility had placed a mannequin in the bed so administration could re-create the scene from the incident the evening prior to this observation. At the time of this observation, the mannequin was still in place and according to NA #1, the room was set up just as it had been the morning of the incident. The door to the room was closed; the bed divider curtain was pulled between bed A and bed B, a 4-drawer dresser was observed in the space between the wall and the left side of Resident #1's bed, and a wheelchair representing Resident #2's wheelchair had been placed at the foot of the bed, facing the head of the bed as it had been during the discovery of the incident. NA #1 demonstrated how she had only been able to lean into the room after pushing the door open approximately 12 inches (as measured by NA #2 with a tape measure as he was present during this room observation). The bed was in a low position, approximately 18 inches from the floor. The mannequin had been placed in the bed to represent Resident #1 and it was lying on its back with its legs spread open at the hips and bent at the knees. NA #1 described how she had observed the positions of both Resident #1 and Resident #2 and stated the light over the head of the bed illuminated the area well enough for her to visualize Resident #1's vagina and clearly see Resident #2 performing oral sex on Resident #1. Based on the surveyor's observation made during this reenactment, it was verified NA #1 would have been able to visualize the position and actions of the residents (Residents #1 and #2) as she described. An interview was conducted with Resident #1's legal guardian on 05/22/24 at 10:39 a.m. The guardian explained she is Resident #1's Guardian Representative while the Director of the [name of] County Department of Social Services is the resident's guardian. The Guardian Representative explained she was informed of the 05/15/24 incident involving Resident #1 and Resident #2 on 05/15/24 and stated it was procedure for her to go to the facility and talk with Resident #1 after an allegation such as this. She spoke with Resident #1 at 1:22 p.m. on 05/15/24 and during her conversation with her, Resident #1 was adamant nothing happened, and that the resident told her that a man tried to get on the bed with her, that she slapped him on the side of his head and told him to get out. During her interview with Resident #1, she stated that she discussed consent with her and asked her what it meant to give consent. The Guardian Representative stated Resident #1 was able to give an accurate definition of consent. The Guardian Representative explained the resident told her she and Resident #2 were not in a relationship, however, they were friends and that he often brought her sodas and they would talk. She said the resident also told her that she and Resident #2 had never talked about sexual activity before and that he had never tried to get into her bed before. The Guardian Representative stated after a bit of talking with Resident #1 that the resident told her she was tired of talking about it and began to pretend cry and repeated I told you, nothing happened. The Guardian Representative explained when she had talked with Nurse #4 earlier that day, she had informed the nurse that Resident #1 was not able to give consent; however, after interviewing Resident #1 herself, she felt that the resident was indeed able to give consent for a sexual act if she wanted that type of relationship. She explained in the past, Resident #1 had been deemed an incompetent adult by the Clerk of Court and said that she informed Nurse #4 of this during their phone conversation. However, after talking with Resident #1, she had been able to name all of her body parts, she knew what sexual activity was, and she knew what consent meant. The Guardian Representative stated that she believed a sexual act between Resident #1 and Resident #2 did occur and stated she felt that Resident #1 denied it because she was embarrassed and scared she might get in trouble. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's Nurse Practitioner (NP) progress note, dated 05/15/24, revealed he had been seen for inappropriate sexual behavior towards a female resident. The note indicated that Resident #2 was witnessed by staff members in a female resident's room at his own will. Staff witnessed this resident giving oral sex to a female resident .this resident was immediately removed from the female resident's room and a sitter was in place. During my assessment, [Resident #2] verbalized to me that he thought he and the female resident were in a relationship. He stated that he assumed this was his girlfriend because he takes her [soda] almost every day. He admitted that he rolled himself into her room. He stated, 'I put my mouth in her private area.' I asked [Resident #2] if she was in agreement. He said, 'Yes.' He said that was when staff caught him in her room .I educated [Resident #2] that this type of behavior cannot occur in this environment. He was educated on the reason why a sitter was in place and why staff changed his room. He did understand . Diagnosis, Assessment and Plan: Inappropriate behavior - sexual inappropriate behavior, including touching, towards a female resident; one-to-one staff at bedside; new room on a different wing . Dementia with behavior problem - .[name of psych nurse practitioner] made aware .; I did report to unit coordinator that resident was able to recall and admit being in a female resident's room. An interview was conducted with the Nurse Practitioner (NP) on 05/22/24 at 10:08 a.m. The NP stated she assessed both Resident #1 and Resident #2 on 05/15/24. She explained she did a head-to-toe assessment on Resident #1 (which included her external genitalia) and there were no signs of trauma. During her examination, she asked Resident #1 questions about the incident, trying to keep the conversation casual. She stated the resident was able to tell her that a bald-headed man in a wheelchair came into her room; she then asked the resident if she had invited him into her room and the resident said no, that he had come in on his own. The NP said she then asked her if the man had touched her and she said no, that he did not touch her or do anything to her. The NP said Resident #1 began to get anxious and she stopped the conversation. The NP clarified that she did not feel Resident #1 was able to consent to a sexual act due to her history with cerebrovascular accident (stroke), dementia, anxiety, depression and a scattered thought process. During her assessment with Resident #2, the NP explained she asked him open-ended questions. The NP stated Resident #2 recalled the police coming to the facility and that he had self-propelled himself into Resident #1's room (who he thought was his girlfriend) and said he put his mouth on her private area. The NP stated she asked Resident #2 if Resident #1 had been in agreement with what he did and said he said yes. The NP stated she explained to Resident #2 that type of behavior was not allowed and explained to him why he had been moved to another room across the building and also that he would have to have a sitter. The NP stated Resident #2 appeared to understand his actions and their consequences and had even asked if Resident #1 was in her right mind. She stated she asked him if Resident #1 had invited him into her room and he told her that he went in on his own. The NP stated Resident #2 is cognitively impaired and is alert and oriented to name and situation but has poor judgment. After completing assessments on both residents, the NP stated she referred both of them to the psychiatric nurse practitioner. A review of Resident #2's psychiatric follow-up evaluation, conducted on 05/15/24 by a behavioral health nurse practitioner (NP), revealed he had been seen per staff request [TRUNCATED]