

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL039021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1287 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 000	Initial Comments The Adult Care Licensure Section and the McDowell County Department of Social Services conducted an annual survey and complaint investigation on September 25-29, 2017, and October 2, 2017. The McDowell County Department of Social Services initiated the complaint investigation on August 25, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the walls, floors and ceilings in 13 residents' rooms and bathrooms (rooms #101, #103, #105, #107, #200, #201, #203, #205, #207, #210, #403, #405, #407), the common bathrooms on 100, 200 and 300 halls even (there are even and odd common bathrooms), the dining room, all hallways, and the common living room on the 400 hall, were kept clean and in good repair. The findings are: Observations during the facility tour on 9/25/17 from 9:00 am till 11:00 am revealed the	D 074		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Janet Veas VP Facility Operations

TITLE

(X6) DATE 11/13/17

STATE FORM 1000 XBP11

Continuation sheet 1 of 189

APPROVED WITH AMENDMENTS
12-15-17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 074	<p>Continued From page 1</p> <p>community bathroom labeled as the "300 hall even bathroom" had a strong smell of urine; the toilet was filled with paper towels; and yellow and brown colored water was present around the toilet on the floor and in front of the toilet.</p> <p>Observation on 9/26/17 at 7:33 am of room #210 revealed:</p> <ul style="list-style-type: none"> -The ceilings were not in good repair because of the cracks in the ceiling, ceiling boards that were not secure (hanging down about 1/4 ") and to the far right wall of the room, the ceiling had holes (1-3" x 2", 1- 1" x 1") with black flaky substance falling out of it, along the ceiling where the ceiling meets the brick wall. -The far right wall ceiling had a 4"x 3" inch hole in the ceiling with small amount of black flaky substance falling from the holes. -There was a small amount of black flaky substance on the floor of the room under all of the hole in the ceiling. -The closet to the right of the entrance was not in good repair because it had missing door facing boards exposing loose wood, and a 6 by 12 inches of wood that was rotten. -To the left of the entrance door was a baseboard heating unit that was not in good repair with loose metal hanging down and a 3 inch hole in the floor in front of that base board unit. -The floor in room #210 was dirty especially around the edges of the room along the walls. <p>Observation on 9/26/17 at 7:33 am of a resident in room #210 revealed, she was not wearing shoes and the bottom of her feet were black with slight bleeding to the wound on the left foot.</p> <p>Interview on 9/26/17 at 7:33 am with the resident residing in room #210 revealed:</p> <ul style="list-style-type: none"> -The room gets a lot of water in the closet and in 	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 2</p> <p>the far right part of the room because of the holes in the ceiling.</p> <ul style="list-style-type: none"> -The "closet floods" when it rains and my stuff gets soaked. -She informed the maintenance man, the Lead Custodian, and the Lead Custodian would assign someone to fix the ceiling. -The Maintenance Director came in and worked on the ceiling to try to stop the leaks before the big rain about 2 weeks ago. -The maintenance man had to put buckets under all of the holes to catch the water and they fill up fast. -They had bad rains about 2 weeks ago and had water in the room from the buckets overflowing. -Her wound "gets dirty because of the dirty floors". <p>Interview on 9/26/17 at 8:05 with a housekeeper revealed:</p> <ul style="list-style-type: none"> -He had worked at the facility for 2 years. -One of his duties was to mop the floors. -Room #210 had water in it about 2 weeks ago after heavy rains. -He had to use the shop vacuum to get the free standing water out of room #210 and its closet. -He put buckets under all of the holes in the ceiling. -He reported the damage to a maintenance assistant. -Several people worked on the ceiling. <p>Interview on 9/26/17 at 8:16 am with a second housekeeper revealed:</p> <ul style="list-style-type: none"> -Room #210 is the only room leaking. -There had been several attempts to fix the leaks in room #210. -The Facility Operations Manager was responsible for hiring the roofers to fix the ceiling and roof. 	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 3</p> <p>-The ceiling still leaks in room #210 with heavy rains and he had to use buckets to catch the water.</p> <p>Review of an email from a local roofer dated 9/28/17 revealed that on 8/17/17 additional roof repairs were done to the roof over room #210 by his company.</p> <p>Observation of Resident Room #405 on 9/25/17 at 10:22am revealed the floor along the left hand side of the room heading into the shared half bath was dirty with paper debris.</p> <p>Observation of the half bath in room #403 on 9/25/17 at 10:25am revealed: -The floor around the toilet base was not clean with an unknown liquid running out into the floor. -The hand sink was not clean with a build up of scum along the top of the sink bowl. -There was a heavy layer of dirty caulking along the back of the sink where it attached to the wall.</p> <p>Observation of room #403 on 9/25/17 at 10:27am revealed: - The wall next to the air conditioning unit was not clean with cobwebs all along the bedroom window where the ceiling meets the wall. -The windowsill next to the air conditioning unit was not clean with a build up of dust and a dead bug.</p> <p>Observation of the half bath in room #407 on 9/25/17 at 10:10am revealed: -The sink was not clean with brown scum along the interior of the sink bowl. -There was paper debris on the bathroom floor including one cigarette butt.</p> <p>Observation of the baseboard heater in the living</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 4</p> <p>room on the 400 hall on 9/25/17 at 10:45am revealed a build up of dust on the entire length of the heater.</p> <p>Observation of the common even bath on the 300 hall at 10:53am on 9/25/17 revealed the base of the toilet was not in good repair with a water accumulating onto the floor.</p> <p>Interview with a housekeeper on 9/25/17 at 9:53am revealed: -He started working at the facility the first of this month (September.) -The facility employed three housekeepers. -There were usually three housekeepers on duty at the facility, Monday through Friday. -One housekeeper worked on the weekend, "we alternate working weekends, I work every other weekend." -As part of normal cleaning, we take out the trash, sweep and mop the floors, and clean the bathrooms every day. -"We try to dust "about twice a week." -"If there is a housekeeping problem that requires immediate attention, the aides will let us know." -The housekeepers keep a list of problems we find in the facility when cleaning, and turn that list in to the Assistant Operations Manager weekly.</p> <p>Interview with a maintenance worker on 9/25/17 at 12:03pm revealed housekeeping staff was short one worker, but they had hired someone to start next week.</p> <p>Observations on 9/25/17 from 9:35am until 12:02pm and 9/26/17 from 4:55am until 7:50am revealed: -The floor at the 100 hall entrance door was dirty with heavy dirt build up around the edges of the threshold plate, at wall corners and where the</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 5</p> <p>baseboard met the floor.</p> <p>-The entrance door to the 100 hall was dirty and not in good repair with a buildup of scuff marks at the bottom of the door and finger prints covering a an area of approximately 3 inches by 12 inches above the door handle on the right side.</p> <p>-The hallway floors on the 100 and 200 hall were dirty with an accumulation of dust on the baseboards and dirt buildup where the baseboard and floor met.</p> <p>-The floors in resident rooms #101, #103, #105, #107, #200, #201, #203, #205 and #207; and the common bathrooms on the 100 and 200 halls were dirty with heavy dirt and dust accumulation on floors under the sinks, under and in front of the baseboard heaters, at the corners of the rooms and around the entrance and bathroom door frames.</p> <p>-The floors in both dining rooms were dirty with heavy dirt and dust build up under and in front of baseboard heaters, around the entrances, at the corners of the rooms and where the baseboards met the floor.</p> <p>Observations on 9/27/17 at 9:00am revealed:</p> <p>-The floor at the 100 hall entrance door was dirty with heavy dirt build up around the edges of the threshold plate, at wall corners and where the baseboard met the floor.</p> <p>-The entrance door to the 100 hall was dirty and not in good repair with a buildup of scuff marks at the bottom of the door and finger prints covering a an area of approximately 3 inches by 12 inches above the door handle on the right side.</p> <p>-The hallway floors on the 100 and 200 hall were dirty with an accumulation of dust on the baseboards and dirt buildup where the baseboard and floor met.</p> <p>-The floors in the common bathrooms on the 100 and 200 halls were dirty with heavy dirt and dust</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 6</p> <p>accumulation on floors under the sinks, under and in front of the baseboard heaters, at the corners of the rooms and around the entrance and bathroom door frames.</p> <p>Observation on 9/27/17 at 12:43pm revealed the floors in both dining rooms were dirty with heavy dirt and dust build up under and in front of baseboard heaters, around the entrances, at the corners of the rooms and where the baseboards met the floor.</p> <p>Interview with a resident on 9/26/17 at 1:44pm revealed: -There were housekeepers who were supposed to clean every day. -The housekeepers cleaned the bathroom and mopped the floor and that was it.</p> <p>Interview with a second resident on 9/25/17 at 11:06am revealed: -The resident cleaned her own room. -The facility had housekeepers that had some kind of schedule. -One day the housekeeper might say they were going to mop the floors and the next day clean the bathrooms.</p> <p>Observation on 9/28/17 at 9:30am revealed there was a resident in a wheel chair wiping down the bottom area of door frames to resident rooms on the 200 hall.</p> <p>Interview with a housekeeper on 9/28/17 at 9:36am revealed: -He had worked at the facility as a housekeeper for one month. -He worked from 7:00am until 3:00pm, Monday through Friday. -He sometimes worked on the weekend as the</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 7</p> <p>only housekeeper then had two days off during the week. -When there was no kitchen staff, one of the housekeepers would work in the kitchen leaving just one housekeeper to clean.</p> <p>-On average each week, a housekeeper would have to work in the kitchen two out of five days Monday through Friday.</p> <p>-It was hard and stressful for one person to clean the entire facility.</p> <p>-The Housekeeping Supervisor was aware and had talked to the Assistant Operations Manager (AOM).</p> <p>-The cleaning of dirt build up on the floors and dust accumulations on floors and baseboard heaters was usually done when the housekeepers did deep cleaning in a resident's room.</p> <p>-The housekeeping staff was doing deep cleaning on the 400 hall and deep cleaned two to four rooms per day every day.</p> <p>Interview with the Housekeeping Supervisor on 9/27/17 at 4:19pm revealed:</p> <p>-He was aware there was dirt and dust build up in resident rooms and in hallways.</p> <p>-The housekeepers were "shorthanded, always shorthanded."</p> <p>-The housekeepers had been working with just one person for "a long time."</p> <p>-The housekeeping staff had just become a "full crew" about three weeks ago.</p> <p>-He declined to answer any further questions.</p> <p>Interview with the Maintenance Man on 9/27/17 at 4:27pm and 9/28/17 9:55am revealed:</p> <p>-He had worked as the Maintenance Man for one and a half years from 7:00am until 4:30pm Monday through Friday.</p> <p>-He was responsible for most repairs including plumbing, walls, painting, doors and "stuff like</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 8</p> <p>that."</p> <ul style="list-style-type: none"> -He was not aware of the condition of the entrance door to the 100 hall. -Staff reported repair needs to the Assistant Operations Manager (AOM) and the AOM instructed him on what needed to be done. -He was not aware of the leakage from the ceiling in resident room #210 before 9/26/17. <p>Interview with the Assistant Operations Manager (AOM) on 9/28/17 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -He was responsible for overseeing the activity program, the kitchen, housekeeping and maintenance and reported to the Operations Manager (OM). -There were four full time housekeepers and he tried to keep two on duty every day. -Recently a housekeeper quit and the facility was short "one housekeeper per day for one day per week" for a period of approximately two weeks. -Housekeepers were expected to prioritize any safety issues by dropping whatever they might be doing and clean up any spills. -Housekeepers were responsible for cleaning hallways, resident rooms, bathrooms and offices daily. -The housekeepers had a daily check off sheet for the rooms they cleaned and a deep cleaning check off sheet for rooms that were deep cleaned. -Housekeepers were responsible for deep cleaning three to four rooms per day every day which averaged out to every resident room being deep cleaned every week. -The deep cleaning schedule had been in effect for one year. -He was responsible for checking the housekeepers work and "periodically, randomly" checked three to four rooms each week to assure the tasks listed on check off sheets had been 	D 074		

Division of Health Service Regulation

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D 074	Continued From page 9 done. -There were two full time maintenance men to handle most repairs.	D 074		
D 075	<p>10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasent odors; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there were no chronic urine, feces, body and mildew odors in three resident rooms (#105, #107 and #207) and in the 100 and 200 hallways.</p> <p>The findings are:</p> <p>Observations on 9/25/17 from 9:35am until 12:02pm revealed: -There was a urine odor in the hall near resident room #107. -There was a strong odor of mold in resident room #105. -There was a strong odor of urine in the 200 hall with increasing intensity near the 200 hall common bathroom and resident room #207. -There was cloudy urine in the toilet inside the common bathroom on the 200 hall. -There was strong body odor in and near resident room #207.</p> <p>Observations on 9/26/17 at 4:55am, 9/27/17 at</p>	D 075		

Division of Health Service Regulation

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D 075	<p>Continued From page 10</p> <p>9:00am and 1:44pm revealed: -There was a strong urine, feces and body odor on the 100 and 200 hall. -There was a strong odor of mold and mildew in resident room #105.</p> <p>Interview with the resident in room #105 on 9/25/17 at 11:33am revealed: -The pipe that ran across the room near the ceiling was leaking about a month ago. -The pipe ran across the room over her bed and leaked onto her bed and clothes. -There was mildew on the clothes in her closet. -She was aware of the mold and mildew odor and it bothered her. -She told the maintenance man who said there was nothing he could do about it.</p> <p>Interview with the Maintenance "Man" on 9/28/17 at 9:55am revealed he was not aware of any potential mold or mildew problem in resident room #105.</p> <p>Observation of Resident #17's room, #206 on 9/29/17 at 11:55 a.m. revealed: -An extremely strong smell of urine and feces was evident from Resident #17's room door.</p> <p>Interview with Resident #17's Guardian on 9/29/17 at 11:57 a.m. revealed: -The resident's bed sheets are always left in urine and soil when he visited Resident #17. -He tried to change Resident #17's bed sheets, wash his clothes, and clean his room when he and a second family member visited every month or so. -Resident #17 said he asked staff last night (9/28/17 -9/29/17) to change his sheets and incontinence pad and they never did. -"The condition of my brother's room was</p>	D 075		

Division of Health Service Regulation

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D 075	<p>Continued From page 11</p> <p>deplorable!" -He and a second family member had contacted Operations Manager (OM), but had not received a response.</p> <p>Observation of Resident #17's room on 10/02/17 at 2:00 p.m. revealed: -A strong smell of urine and feces was evident from Resident #17's room door. -There was a soiled large incontinence pad on his bed. -The fitted and flat sheets were stained with dried urine and feces. -The pillowcase and pillow had dried yellowish brown stains.</p> <p>Interview with Resident #17 on 10/02/17 at 2:08 p.m. revealed: -In response to had staff checked on you today the resident stated, "Do you see anybody?" -He had to lay on his bed when it was wet and soiled because he had no choice.</p> <p>Interview with a Personal Care Aide (PCA) on 10/2/17 at 1:21 p.m. revealed: -She had done Resident #17's laundry last Wednesday (9/27/17) and she had not checked the resident's laundry on 10/2/17. -Resident #17 did not complain, if staff asked him if he needed his bed changed the resident would say if you want to. -Staff checked Resident #17 every two hours for incontinence.</p> <p>Interview with the OM and Administrator on 10/2/17 at 2:39 p.m. revealed: -The OM was aware of the condition of Resident #17's room on 9/29/17, but not on 10/2/17 at 2:00pm. -The Administrator was not aware of the condition</p>	D 075		

Division of Health Service Regulation

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D 075	<p>Continued From page 12</p> <p>of Resident #17's room.</p> <p>-Anytime Resident #17 had an issue he would come to the OM and he had not reported any concerns to the OM in "quite some time" meaning at least a month.</p> <p>Interview with a resident on 9/26/17 at 4:45pm revealed there was always an odor of urine and feces in the facility, especially on the 3rd shift.</p> <p>Interview with a Housekeeper on 9/28/17 at 10:05am revealed:</p> <p>-He was aware of the urine and feces odor on the 100 hall.</p> <p>-There was a resident in room #107 that had "a lot" of accidents.</p> <p>-The housekeepers tried to stay on top of that by cleaning up any accidents with the "proper chemicals."</p> <p>-It was hard to stay on top of the clean ups when there was just one housekeeper on duty.</p> <p>Interview with the Assistant Operations Manager (AOM) on 9/28/17 at 3:30pm revealed:</p> <p>-He was aware there were urine, feces and body odors on the 100 and 200 halls.</p> <p>-He did not think the odors were persistent.</p> <p>-He thought the odors built up overnight.</p> <p>-The housekeepers clean, the residents urinate throughout the day and that was where the odor came from.</p> <p>-The building was cleaned throughout the day and by the end of the work day, the odors were gone.</p> <p>-The main hall (common) bathrooms were cleaned three times per day; in the morning, midday and before the housekeepers left for the day.</p> <p>-He was aware of the condensation on the pipe in resident room #105.</p>	D 075		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 075	Continued From page 13 -It was not a year round problem, occurred mostly on hot, humid days and resolved itself when the weather changed.	D 075		
D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the environment in 9 resident rooms and common bathrooms on the 100, 200 and 400 hall were kept in a clean, in an orderly manner and free of hazards such-as feces on shared toilets, overflowing closets and leaking showers and urinals.</p> <p>The findings are:</p> <p>Observations on 9/25/17 from 9:35am until 12:02pm revealed: -The window blinds and the window sills were not clean in resident rooms #101, #103, #105, #107, #200, #201, #203, #205 and #207; and the common bathrooms on the 100 and 200 hall bathrooms where there was dirt and dust accumulations.</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 079	<p>Continued From page 14</p> <ul style="list-style-type: none"> -The sink area was not clean in resident room #101, with heavy scum buildup in and around the sink and a large cobweb above the sink. -The sink was not clean in resident room #103, with scum build up around the sink and a blue stain inside the sink. -The toilet in the shared bathroom between resident rooms #105 and #107 was not clean and hazardous as a shared bathroom with brown marks resembling feces on the toilet seat, on the side of the toilet and on the walls around the toilet. -There was clutter overflowing from the closet in resident room #105 where there were clothes in black garbage bags and loose clothing on the floor narrowing the entrance/exit of the room by approximately 12 to 18 inches. -The sinks were not clean in resident rooms #105, #200, and #203, with scum build up in and around the sinks. -The box spring was not clean on the first bed in resident room #107, with brown spots and dirt accumulations around the edges. -There was hazard of a splintered wooden floor transition board on the floor in front of the walk-in shower in the common bathroom on the 100 hall. -The shower was not clean in the common bathroom where there was a shower chair that had dirt/scum build up on the seat, dirt along the edges of the shower floor, soiled wash clothes on the shower floor and a wet, used bandage on the shower floor. -An oxygen concentrator was not clean in resident room #201, where there was heavy dust accumulations on the top of the concentrator. -The tub was not clean in the common bathroom on the 200 hall, with scum buildup around the bottom half of the tub. -There was clutter consisting of dirty laundry piled up on the floor in resident room #207. 	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 079	<p>Continued From page 15</p> <p>Interview with the resident in room #101 on 9/25/17 at 10:12am revealed: -The spider web above the sink had been there for four months. -She had asked staff to get the web down, but no one had done it.</p> <p>The resident in room #201 was not available for interview secondary to being hospitalized as of 9/20/17.</p> <p>Interview with the resident in room #107 on 9/25/17 at 11:41am revealed she thought the box springs "came that way."</p> <p>Interview with a second resident on 9/25/17 at 10:45am revealed the facility bathrooms were "unbelievably bad" and often there was not a clean bathroom open for use.</p> <p>Interview with a third resident on 9/25/17 at 11:06am revealed: -The bathrooms in the facility were "really gross." -The resident used wipes to clean the toilet before using it. -The resident also cleaned her own room. -The bathtubs stayed "nasty." -The facility had housekeepers that had some kind of schedule. -One day the housekeeper might say they were going to mop the floors and the next day clean the bathrooms.</p> <p>Observations on 9/26/17 at 6:15am revealed: -There was a slip hazard of a large amount of water (covering an area larger than an average sized bath mat) on the floor in front of the shower in the common bathroom on the 400 hall. -There was a shower curtain hanging in the</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 079	<p>Continued From page 16</p> <p>shower.</p> <p>-There was a slip hazard of a large amount of water (covering an area approximately equal to the size of an average bath mat) on the floor under the urinal in the common bathroom on the 400 hall.</p> <p>Interview with a Personal Care Aide (PCA) on 9/26/17 at 6:16am revealed:</p> <p>-The shower in the common bathroom on the 400 hall leaked every time a resident took a shower.</p> <p>-The urinal in the common bathroom on the 400 hall "was usually okay."</p> <p>Observation of Resident #17's room, #206, on 9/29/17 at 11:55 a.m. revealed:</p> <p>-There was a medium sized white basket on the floor by the room entrance piled high with dirty laundry.</p> <p>-A small pile of dirty laundry was on the floor by the medium sized white basket.</p> <p>-There were clothes piled on the chair and on the floor, that were also stained in the brown color.</p> <p>-There were empty plastic water bottles and soda cans in the window seal.</p> <p>-The window seal was dirty.</p> <p>Interview with Resident #17's Guardian on 9/29/17 at 11:57 a.m. revealed:</p> <p>-The resident's bed sheets are always left in urine and soil when he visited Resident #17.</p> <p>-He tried to change Resident #17's bed sheets, wash his clothes, and clean his room when he and a second family member visited every month or so.</p> <p>-Resident #17 said he asked staff last night (9/28/17) to change his sheets and incontinence pad and they never did.</p> <p>-"The condition of my brother's room were deplorable!"</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

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D 079	<p>Continued From page 17</p> <p>-He brought his own cleaning supplies to clean Resident #17's room.</p> <p>-He and a second family member had contacted the Operations Manager, but had not received a response.</p> <p>Observation of Resident #17's room on 10/02/17 at 2:00 p.m. revealed:</p> <p>-The fitted and flat sheets were stained with dried urine and feces.</p> <p>-The pillowcase and pillow had dried yellowish brown stains.</p> <p>-The stain was dried on the outer perimeter and went from yellow to brown in color.</p> <p>-The window seal was dirty.</p> <p>Interview with Resident #17 on 10/02/17 at 2:08 p.m. revealed:</p> <p>-In response to had staff checked on you today the resident stated, "Do you see anybody?"</p> <p>-Staff helped him with incontinence care at bedtime, but that was it.</p> <p>-Staff did not check on him through the night or during the day.</p> <p>-When staff come to check on him, he allowed them to help him and did not refuse.</p> <p>-He had to lay on his bed when it was wet and soiled because he had no choice.</p> <p>Interview with a Medication Aide (MA) on 9/26/17 at 5:15pm revealed she was "rarely on the floor" and was not aware of the condition of the residents' rooms.</p> <p>Interview with a housekeeper on 9/28/17 at 9:36am revealed:</p> <p>-He had worked at the facility as a housekeeper for one month.</p> <p>-He worked from 7:00am until 3:00pm, Monday through Friday.</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2017
NAME OF PROVIDER OR SUPPLIER CEDAR BROOK RESIDENTIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761		
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D-079	Continued From page 18: -He sometimes worked on the weekend as the only housekeeper then had two days off during the week. -When there was no kitchen staff, one of the housekeepers would work in the kitchen leaving just one housekeeper to clean. -On average each week, a housekeeper would have to work in the kitchen two out of five days Monday through Friday. -It was hard and stressful for one person to clean the entire facility. -The Housekeeping Supervisor was aware and had talked to the Assistant Operations Manager (AOM). -He was responsible for cleaning up any safety issues like spills on the floor immediately. -He was responsible for cleaning the common bathrooms, residents' rooms and shared bathrooms in residents' rooms. -The cleaning of dirt and dust accumulations on window sills was usually done when the housekeepers did deep cleaning in a resident's room. -The housekeeping staff was doing deep cleaning on the 400 hall and deep cleaned two to four rooms per day every day. -The sinks in residents' rooms were cleaned every day, but the residents would go in after the sink was cleaned and pour coffee and drinks in the sink staining the sink. Interview with the Housekeeping Supervisor on 9/27/17 at 4:19pm revealed: -He was aware there was dirt and dust build up in resident rooms and in hallways. -The housekeepers were "shorthanded, always shorthanded." -The housekeepers had been working with just one person for "a long time." -The housekeeping staff had just become a "full	D 079	Amended 12/4/17 A member of management or designee will do walk through of building no less than weekly and areas identified will be addressed.	11/15/17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 079	<p>Continued From page 19</p> <p>crew" about three weeks ago. -He declined to answer any further questions.</p> <p>Interview with the maintenance man on 9/27/17 at 4:27pm and 9/28/17 at 9:55am revealed: -He had worked as the Maintenance "Man" for one and a half years from 7:00am until 4:30pm Monday through Friday. -He was responsible for most repairs including plumbing, walls, painting, doors and "stuff like that." -He was not aware of the splintered transition board on the floor in the shower in the 100 hall common bathroom and the water on the floor by the urinal and shower in the common bathroom on the 400 hall. -Staff reported repair needs to the Assistant Operations Manager (AOM) and the AOM instructed him on what needed to be done.</p> <p>Interview with the Assistant Operations Manager (AOM) on 9/28/17 at 3:30pm revealed: -He was responsible for overseeing the activity program, the kitchen, housekeeping and maintenance and reported to the Operations Manager (OM). -There were four full time housekeepers and he tried to keep two on duty every day. -Recently a housekeeper quit and the facility was short "one housekeeper per day for one day per week" for a period of approximately two weeks. -Housekeepers were expected to prioritize any safety issues by dropping whatever they might be doing and clean up any spills. -Housekeepers were responsible for cleaning hallways, resident rooms, bathrooms and offices daily. -The housekeepers had a daily check off sheet for the rooms they cleaned and a deep cleaning check off sheet for rooms that were deep</p>	D 079		

Division of Health Service Regulation

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D 079	Continued From page 20 cleaned. -Housekeepers were responsible for deep cleaning three to four rooms per day every day which averaged out to every resident room being deep cleaned every week. -The deep cleaning schedule had been in effect for one year. -He was responsible for checking the housekeepers work and "periodically, randomly" checked three to four rooms each week to assure the tasks listed on check off sheets had been done. -There were two full time maintenance men to handle most repairs. -The shower in the common bathroom on the 400 hall was not leaking, it was missing a shower curtain which was replaced on 9/27/17. -He was "not convinced the urinal was actually leaking" and thought it "might just be urine" on the floor.	D 079		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 188	<p>Continued From page 21</p> <p>10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.</p> <p>(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 6 of 21 shifts resulting in inadequate staff to meet the supervision, incontinence care and bathing needs of residents.</p> <p>The findings are:</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 188	<p>Continued From page 22</p> <p>Confidential interview with a resident revealed: -There was not enough staff to supervise residents who were known to have "violent temper tantrums" like Resident #6. -There were residents who were not being taken care of and would have the same clothes on three to four days in a row. -The 3rd shift staff were "all bad apples" and spent the entire night on their phone or outside smoking cigarettes 40 minutes at a time. -There were "too many of them [staff] that didn't give a (explicit)."</p> <p>Confidential interview with a second resident revealed: -Staff were supposed to be outside supervising residents who were smoking. -Resident #6 had been outside throwing chairs and breaking the chairs more than once in the last few months. -There were residents who made other residents uncomfortable by persistently trying to talk to residents, going in other residents' rooms and taking other residents' belongings. -There was just not enough staff to supervise the residents.</p> <p>Confidential interview with a staff revealed: -Staff at the facility were "busy as (explicit)" and there were not enough staff. -The staff were busy dealing with residents who manipulated the staffs' time to get what they wanted and with residents fighting with other residents. -Residents who needed help with showers and personal hygiene that were quiet and kept to themselves were overlooked and neglected. -There were residents who provoked other residents and wandered into other residents'</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 188	<p>Continued From page 24</p> <p>census for 8/31/17 revealed: -The census documented there were 70 residents in the facility on 8/31/17 which required 28 aide hours for 2nd shift. -The staff time cards documented 18.75 aide hours for 2nd shift on 8/31/17 leaving the facility short 9.25 aide hours.</p> <p>Review of staff time records and the facility census for 9/1/17 revealed: -The census documented there were 69 residents in the facility on 9/1/17 which required 28 aide hours for 2nd shift. -The staff time cards documented 14.5 aide hours for 2nd shift on 9/1/17 leaving the facility short 12.5 aide hours.</p> <p>Review of staff time records and the facility census for 9/20/17 revealed: -The census documented there were 70 residents in the facility on 9/20/17 which required 28 aide hours for 1st and 2nd shift; and 24 aide hours for 3rd shift. -The staff time records documented 26.5 aide hours for 2nd shift on 9/20/17 leaving the facility short 1.5 aide hours. -The staff time card records documented 12.25 aide hours for 3rd shift on 9/20/17 leaving the facility short 11.75 aide hours.</p> <p>Telephone interview with a MA on 10/2/17 at 10:39am revealed: -She worked 3rd shift on 9/20/17. -She could not remember who she worked with or how many staff were on duty that night. -The Operations Manager (OM) and the Resident Care Coordinator (RCC) did work some shifts when the facility was short of staff. -She could not remember if the RCC or the OM worked 3rd shift on 9/20/17.</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 188	<p>Continued From page 25</p> <p>Interview with a second PCA on 9/26/17 at 5:00 am revealed: -There were two to three staff members every night, two PCAs and one MA. -Occasionally there were three PCAs, but not often. -Staff call the OM with any issues with staff sick or calling out. -The OM lives "500 ft in front of facility".</p> <p>Interview with a second MA on 9/26/17 at 12:15pm and 10/2/17 at 12:41pm revealed: -The shift times were 7:00am until 3:00pm for 1st shift, 3:00pm until 11:00pm for 2nd shift and 11:00pm until 7:00am for 3rd shift. -The MAs were responsible for covering the floor while the PCAs took their meal break. -There was staff on the floor at all times.</p> <p>Interview with a third MA on 9/26/17 at 5:15pm revealed she was "rarely on the floor" and therefore was not in resident rooms to observe the condition of the rooms.</p> <p>Telephone interview with a fourth MA on 10/2/17 at 10:40am revealed: -She worked 3rd shift. -"Typically if the Resident Care Coordinator (RCC) or the OM worked 3rd shift, they worked as the MA/Supervisor." -The RCC or OM working meant the MA was not working on the same shift and would have been off duty.</p> <p>Interview with the OM on 10/2/17 at 2:39pm and 3:55pm revealed: -The facility was never short staffed because either she or the Administrator would work to cover any short staffed shifts.</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 188	<p>Continued From page 26</p> <p>-Both she and the Administrator worked on 6/27/17, 8/28/17; 8/31/17, 9/1/17 and 9/20/17, but she did not have the exact hours they worked as direct care staff (MA or PCA role) on each day.</p> <p>Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type B Violation)</p> <p>Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type A2 Violation)</p> <p>The facility's failure to assure adequate staffing for 6 shifts resulted in inadequate staff to respond to the incontinence care, bathing needs and supervision of residents. This failure was detrimental to the safety and well being of all residents which constitutes a Type B Violation.</p> <p>Review of the Plan of Protection submitted by the facility on 9/29/17 revealed: -The facility will staff appropriately to meet the needs of the residents. -Regulations will be followed regarding use of staff for duties other than clinical services. -The OM or designated management staff will review staffing each day to assure the facility is in compliance.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2017.</p>	D 188		
D 189	<p>10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing</p> <p>10A NCAC 13F .0604 Personal Care And Other Staffing</p> <p>(e) Homes with capacity or census of 21 or more</p>	D 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 189	<p>Continued From page 27</p> <p>shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.</p> <p>(2) The following describes the nature of the aide's duties, including allowances and limitations:</p> <p>(A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents.</p> <p>(B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty.</p> <p>(C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks.</p> <p>(D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty.</p> <p>(E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.</p>	D 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 189	<p>Continued From page 28</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure the primary job responsibility of the Personal Care Aides (PCAs) was to provide direct personal care and supervision as evidenced by PCAs assigned dual roles such as transportation, laundry and dietary aide resulting in a lack of incontinence care, bathing and supervision of residents with known aggressive, wandering and self-harming behaviors.</p> <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> -There was not enough staff at the facility and the staff that was in the facility was busy doing laundry or outside on their phones. -There was not enough staff to supervise residents who were known to have "violent temper tantrums" like Resident #6. -There were residents who were not being taken care of and would have the same clothes on three to four days in a row. -There was a staff person specifically for laundry, but the staff stopped working at the facility two to three months ago and the facility did not rehire a laundry person. -Residents would go two to three weeks without getting their laundry cleaned. -There were a couple of Personal Care Aides (PCAs) on 1st and 2nd shift who worked hard helping the residents and cleaning laundry. -The 3rd shift staff were "all bad apples" and spent the entire night on their phone or outside smoking cigarettes 40 minutes at a time. -There were "too many of them [staff] that didn't 	D 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 189	<p>Continued From page 29 give a (explicit)."</p> <p>Confidential interview with a second resident revealed: -Staff were supposed to be outside supervising residents who were smoking. -Resident #6 had been outside throwing chairs and breaking the chairs more than once in the last few months. -There were residents who made other residents uncomfortable by persistently trying to talk to residents, going in other residents' rooms and taking other residents' belongings. -Staff were not able to do anything about the residents' behaviors because they were busy helping residents with showers, giving medications and helping to serve the food. -There was just not enough staff to supervise the residents. -The facility needed a separate laundry person. -The 1st shift PCAs started laundry, 2nd shift PCAs did not do laundry and certain PCAs on 3rd shift did laundry.</p> <p>Confidential interview with a staff revealed: -Staff at the facility were "busy as (explicit)" and there were not enough staff. -The staff were busy dealing with residents who manipulated the staffs' time to get what they wanted and with residents fighting with other residents. -Residents who needed help with showers and personal hygiene that were quiet and kept to themselves were overlooked and neglected. -There were residents who provoked other residents and wandered into other residents' rooms when they knew staff were busy or when residents were lined up for medications or food.</p> <p>Interviews with four additional staff on 9/25/17</p>	D 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 189	<p>Continued From page 30</p> <p>between 10:35am and 4:15pm revealed Staff K performed laundry and housekeeping duties while working 1st shift.</p> <p>Observations on 9/29/17 at 6:50pm revealed: -There was a Medication Aide (MA) and two PCAs eating dinner together in the staff break room. -There were a minimum of twenty residents lined up in the hallway between the dining room and the medication room and in the common area next to the medication room. -There was no staff present in the hallway or common area.</p> <p>Interview with a MA on 9/26/17 at 5:15pm revealed she was "rarely on the floor" and therefore was not in resident rooms to observe the condition of the rooms.</p> <p>Interview with Staff J on 9/26/17 at 8:00am, 10:25am and 12:30pm revealed: -He worked as both a PCA and as transportation for residents' appointments. -If there were not many appointments, then he was able to work as a PCA and "help out on the floor." -He assisted in the dining room at meal times by seating residents and bringing residents their plates and drinks. -He was working as a PCA on 9/26/17 but had to leave the facility at 1:05pm to take a resident to an appointment.</p> <p>Review of untitled documents hand written by the Operations Manager (OM) listing staff on duty for 9/25/17 and 9/26/17 revealed: -Staff J was listed as working 1st shift as transportation for 9/25/17 and 9/26/17. -In addition to Staff J, there were two PCAs and</p>	D 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2017
NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1257 PINNACLE CHURCH ROAD NEBO, NC 28761		
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D 189	<p>Continued From page 31</p> <p>two MAs on the schedule for 9/26/17.</p> <p>Interview with a second MA on 9/26/17 at 11:55am revealed Staff J worked as transportation and a PCA.</p> <p>Interview with a PCA (Staff K) on 10/2/17 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -She worked as a PCA, as a MA and also helped with laundry. -She only stayed in the laundry room and did laundry when there were enough aides on the floor (four PCAs). -Otherwise, she would have to "throw clothes in the wash" in between taking care of the residents. -Staff K was usually the third PCA on duty and was usually in the hallway to monitor residents in the hallway and outside during meal times. -Some of the MAs would come out of the medication room and help do 15 minute checks or help serve during meal times. <p>Interview with the Operations Manager (OM) on 10/2/17 at 2:39pm and 3:56pm revealed:</p> <ul style="list-style-type: none"> -Staff J was both transportation and a PCA. -Some days Staff J worked a full day as the transportation person and some days it might be four hours. -There a few staff that did transportation because there were often conflicting appointment times. -She could not say off hand which days Staff J worked as transportation or as a PCA. -Staff K only did laundry on 1st shift if there were extra aides on duty. <p>Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type B Violation)</p> <p>Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type A2 Violation)</p>	D 189	<p>Ammended 12/14/17</p> <p>- Facility management and supervisors assign Personal care Aide staff to perform duties other than Personal care Aide duties only when staffing exceeds required levels. This will be monitored daily</p>	10/2/17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 189	<p>Continued From page 32</p> <hr/> <p>The facility's failure to assure adequate staffing for 6 shifts resulted in inadequate staff to respond to the incontinence care, bathing needs and supervision of residents. This failure was detrimental to the safety and well being of all residents which constitutes a Type B Violation.</p> <hr/> <p>Review of the Plan of Protection submitted by the facility on 9/29/17 revealed: -The facility will staff appropriately to meet the needs of the residents. -Regulations will be followed regarding use of staff for duties other than clinical services. -The OM or designated management staff will review staffing each day to assure the facility is in compliance.</p> <p>THE DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2017.</p>	D 189		
D 255	<p>10A NCAC 13F .0801(c)(1) Resident Assessment</p> <p>10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer;</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 255	<p>Continued From page 33</p> <p>(C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure an assessment for 2 of 2 sampled residents (#4, #7) was reviewed with significant changes, including deterioration in three activities of daily living in the areas of bathing, grooming, and dressing were</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 255	<p>Continued From page 34</p> <p>completed within 10 days of the change in the residents' condition.</p> <p>The findings are:</p> <p>A. Review of the current FL-2 dated 4/06/17 for Resident #4 revealed: -Diagnoses of urinary incontinence, hypothyroidism, vitamin D deficiency, myopia, history of left ovarian cyst, anti-social traits, paranoid schizophrenia. -Incontinent bladder.</p> <p>Review of Resident Register revealed Resident #4 was admitted to the facility on 4/28/2015.</p> <p>Review of Care Plan dated 4/06/17 for Resident #4 revealed: -Resident #4 had poor hygiene and required "strong encouragement" to bathe and to change clothing. -Resident #4 required "no assistance" from staff with bathing, grooming, and personal care. -Resident #4 was independent in the areas of bathing, grooming, and dressing.</p> <p>Review of Resident #4's Primary Care Provider notes on 5/11/17 revealed "very poor hygiene" was noted for dental. Staff were to encourage tooth brushing twice daily.</p> <p>Review of the shower schedule revealed Resident #4 was a 2nd shift shower on Tuesdays with all other days noted to be sponge bath days.</p> <p>Observations of Resident #4 on 9/25/17 at 11:45 a.m. through 9/29/17 revealed: -Resident #4's hair was uncombed and disheveled. -She had on the same clothing for four days</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055621	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/02/2017
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D 255	<p>Continued From page 35</p> <p>9/25/17 through 9/28/17</p> <p>-Her face was unwashed and clothing, ill-fitting.</p> <p>Interview with Resident #4 on 9/27/17 at 1:44 p.m. revealed:</p> <p>-It had been about a month since her sheets and blanket had been washed.</p> <p>-Staff were supposed to clean the bed linens weekly.</p> <p>-Staff did not come and prompt her to take a shower or ask if she needed any assistance.</p> <p>-She was aware of the smell in her room and on her person and the smell did bother her.</p> <p>Interview with Primary Care Provider (Nurse Practitioner) on 9/28/17 at 4:50 p.m. revealed:</p> <p>-Personal care is a major issue for Resident #4.</p> <p>-Resident #4 has a strong body odor.</p> <p>-She can physically bathe herself but needed continuous encouragement from staff to bathe and to groom herself.</p> <p>-He has not been informed of any personal care concerns regarding Resident #4.</p> <p>-Staff were asked to use redirection and encouragement when assisting Resident #4 with bathing, grooming, and dressing.</p> <p>Interview with staff (Medical Office Assistants and one Primary Care Provider) from the Nurse Practitioner's office (NP) on 10/02/17 at 9:50 a.m. revealed:</p> <p>-The facility had not called their office about bathing refusals for Resident #4.</p> <p>-Staff were told to continue to prompt and encourage bathing and grooming, even if it wasn't Resident #4's bath day.</p> <p>-Facility staff were to encourage Resident #4 to wear shoes, which she doesn't like to do.</p> <p>Interview with the Mental Health Support Team</p>	D 255	<p>Amended 12/14/17</p> <p>- Resident assessments will be reviewed no less than monthly by administrator or operations manager to ensure accuracy when completed.</p>	11/15/17	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 255	<p>Continued From page 36</p> <p>(MHST) of Resident #4 on 9/29/17 at 9:45 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #4 has great difficulty with personal hygiene. -Her body odor was "intense" and the MHST had spoken openly with Resident #4 regarding her personal care. -She was receptive to the task of bathing and grooming at times but could be noncompliant when it was time to perform those tasks. -Personal hygiene had always been an issue for the resident but it worsened after she quit her job in mid-August 2017. -Resident #4 quit her job because she did not want to work with a peer anymore. -Resident #4's personal hygiene was poor before she quit her job in mid-August of this year but her body odor was less and her physical appearance better when she was working. -Resident #4 responded well to reassurance and encouragement to bathe and groom herself. -Resident #4's personal hygiene worsened after she was no longer employed. -The MHST had developed strategies for staff to use when assisting with Resident #4 with personal care tasks prior to her quitting her job. -MHST were not sure if those personal care strategies for staff were being followed when providing care to Resident #4 after quitting her job. <p>Interview with a Personal Care Aide (PCA) on 10/2/17 at 1:21 p.m. revealed:</p> <ul style="list-style-type: none"> -She had "actually gotten" Resident #4 to take a shower on 10/2/17. -She went down and talked to Resident #4 and Resident #4 asked if it was her shower day. -She told Resident #4 that the resident had missed quite a few shower days and the resident asked if she would have her shower supplies, 	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 255	<p>Continued From page 37</p> <p>who was in the shower area, if the door would be locked and if the PCA would stay outside the door.</p> <ul style="list-style-type: none"> -She reassured Resident #4 that she would have supplies, no one else was in the shower room, the door would be locked and the PCA would stay outside the door. -She had worked third shift and that was when Resident #4 usually took a shower, but had stopped taking showers on 3rd shift. -Resident #4 did not "work well with all staff," just a few. -She talked with the other staff working on 10/2/17 about what she learned to help Resident #4 with her personal care. <p>Interview with the Clinical Operations Manager (COM) on 10/2/17 at 2:39 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #4 did not receive personal care assistance because she was able to bathe herself. -Resident #4 had highs and lows with bathing herself. -The facility staff met with Resident #4's Mental Health Provider (MHP) every week to discuss any concerns and patterns of behavior. -Several weeks back the facility and the MHP discussed possible discharge for Resident #4 because of her body odor. -Resident #4 was receptive to the plan and was doing well until recently where she seems to have declined again. -Staff had been instructed to encourage Resident #4 to bathe. -The mental health support team (MHST) came to the facility and took Resident #4 to do her laundry offsite. -The MHST was at the facility every week and interacted directly with the medication room staff on any concerns about Resident #4. 	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 255	<p>Continued From page 38</p> <p>-The concern for Resident #4's personal hygiene has risen again and the facility contacted Resident #4's guardian last week (9/25/17) about possible discharge of Resident #4 from the facility.</p> <p>Interview with the Administrator on 9/29/17 at 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #4 did not need any bathing assistance because the resident was able to bathe herself. -Resident #4 refused to bathe every week. -The mental health support team was in the facility three to four time each week and was aware of Resident #4's body odor. <p>Interview with the Facility Owner on 9/29/17 at 4:21 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #4 receive mental health services because she qualified for services related to diagnoses of Paranoid Schizophrenia. -Resident #4 had a Person-Centered Plan and Mental Health Assessment provided by her mental health support team which the facility used to develop the resident's care plan. -All care and assistance provided was based on the care plans. -Resident #4 was given a discharge notice a couple of months ago, because the facility could not "get through to her regarding personal care." -The facility met with Resident #4's mental health support team and guardian and developed a plan. -The Mental Health Provider (MHP) met with Resident #4 about the plan. -Resident #4 was given 30 days to comply with the plan or she would be "terminated." -The facility met with the mental health support team every week where the mental health support team explained to the facility what their plan was for Resident #4. -The facility put Resident #4's care plan "inside 	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 255	<p>Continued From page 39</p> <p>their (mental health support team) psychiatric treatment plan."</p> <p>-The facility kept in "close contact" with the mental health support team and kept notes of the concerns that were discussed in weekly meetings.</p> <p>-Resident #4 had made progress, had community employment and was keeping up on her hygiene.</p> <p>-Resident #4 then started to deteriorate and the facility contacted the mental health support team last week (9/25/17) to give notice that care could not be provided related to Resident #4's body odor and personal care.</p> <p>-There were extensive notes to prove the facility did everything possible for Resident #4. (The extensive notes referenced were not provided prior to survey exit).</p> <p>Attempted Interview with Resident #4's guardian on 10/02/17 at 11:00 a.m. was unsuccessful.</p> <p>Refer to confidential interview with a resident.</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am.</p> <p>Refer to interview with a Medication Aide (MA) on 10/2/17 at 12:41pm.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm.</p> <p>B. Review of current FL-2 dated 6/01/17 for Resident #7 revealed:</p> <p>-Diagnoses of schizophrenia, history of polysubstance abuse, hepatitis B deferred, insomnia, tobacco use, history of asthma, and chronic obstructive pulmonary disease.</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 255	<p>Continued From page 40</p> <p>-Incontinent at times; wore pull-ups. -Required limited personal care assistance in the areas of bathing and dressing.</p> <p>Review of Resident Register revealed Resident #7 was admitted to the facility on 8/28/2006.</p> <p>Review of Care Plan dated 4/06/17 for Resident #7 revealed Resident #7 was "independent" in the areas of bathing, grooming, and personal care.</p> <p>Observations of Resident #7 from 9/25/17 at 10:00 a.m. through 10/02/17 at 2:00 p.m. revealed: -Resident #7 was unshaved/ungroomed, had disheveled, uncombed hair, and wore ill-fitting clothes. -Resident #7's clothing was soiled with stains on his pants. -Resident #7 wore the same clothes from 9/25/17 through 9/28/17.</p> <p>Review of the shower schedule revealed Resident #7 was to receive a shower on 2nd shift on Tuesdays with all other days noted to be sponge bath days.</p> <p>Telephone interview with Resident #7's Primary Care Provider (PCP) on 9/28/17 at 4:35pm revealed: -Resident #7 needed limited assistance with bathing, grooming, and dressing. -Resident #7 preferred to keep to himself and may not talk to others. -He was not aware of any personal hygiene concerns regarding Resident #7.</p> <p>Attempted Interview with Resident #7, who was guardian of self, on 10/02/17 at 11:05 a.m. was unsuccessful.</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 255	<p>Continued From page 41</p> <p>Refer to confidential interview with a resident.</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30 a.m.</p> <p>Refer to interview with a Medication Aide (MA) on 10/2/17 at 12:41 p.m.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23 p.m.</p> <p>Refer to interview with the Operations Manager (OM) on 10/2/17 at 2:29 p.m.</p> <p>Refer to interview with the Owner on 9/29/17 at 4:21 p.m.</p> <p>Confidential interview with a resident revealed: -On the 3rd shift, the facility smelled like urine and feces because resident who needed to be changed were not changed all night. -Residents who had not been changed would come into the dining room and sit down for breakfast "reeking of urine and feces" while other residents were trying to eat. -There were residents who walked around the facility in the same clothes for three and four days in a row.</p> <p>Confidential interview with a staff revealed: -Staff was concerned that residents should not be treated like they were being treated. -Staff was in and out of a lot of residents' rooms during 1st shift and noticed that if residents were quiet and stayed to themselves they were "overlooked" by staff. -Those residents would not get help with their</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 255	<p>Continued From page 42</p> <p>personal hygiene like showers and getting their nails trimmed.</p> <p>-The staff were always busy dealing with residents who were fighting and manipulating the staff to get the cigarettes and soda the residents wanted.</p> <p>-There were not enough staff to take care of the residents.</p> <p>Interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am revealed:</p> <p>-She worked 1st shift and usually arrived early to work to see if 3rd shift staff needed help.</p> <p>-All of the PCAs on duty each day were responsible for all of the residents.</p> <p>-Residents were not assigned to a particular PCA for showers; halls were not assigned to any particular PCA either.</p> <p>-The PCAs knew which residents needed shower and toileting assistance based on what was in the PCS (Personal Care Services) book.</p> <p>-The PCS book had the residents who received the 80 hours of personal care services such as bathing, toileting, dressing and help with transfers.</p> <p>-There were approximately 30 residents receiving PCS assistance in the facility.</p> <p>-There was a deviation page with each residents PCS record.</p> <p>-Staff documented any resident refusals to shower, refusals to be shaved if the resident was a man and refusals to eat.</p> <p>-The PCAs on duty communicated with each other to know who had done what for each resident and worked as a team.</p> <p>-She was not aware of any residents in particular who were difficult to bath or gave staff a hard time about bathing.</p> <p>Interview with a Medication Aide (MA) on 10/2/17</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 255	<p>Continued From page 43</p> <p>at 12:41pm revealed:</p> <ul style="list-style-type: none"> -There was a bathing schedule posted in the staff break room where residents were assigned showers for 1st or 2nd shift. -If the resident had an incontinence episode and needed bathing, they would be bathed. -The PCA's were supposed to let the MAs know if a resident refused to bath or shower. -She "really did not have an explanation for" Resident #17 and the condition of his room and bed on 9/29/17. -The PCAs worked together and chose which residents they were going to shower each shift. -If the PCAs were unable to choose themselves, then the MAs would assign resident to shower to each PCA on duty. <p>Interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm revealed:</p> <ul style="list-style-type: none"> -There was a bathing schedule posted in the staff break room. -If a resident refused a shower, the personal Care Aide (PCA) let the medication room staff (MAs) know. -The medication room staff usually tried to get the resident to take a shower. -If the resident continued to refuse that was their right. -Staff would try giving an as needed medication for some residents to help with showers. -The next shift would also try to give showers for any resident that had refused. -A lot of the time, the PCAs would split the showers for the shift and other times one PCA might get the showers done while the other PCA does other tasks. -Some staff were good at getting the showers done. <p>Interview with the Operations Manager (OM) on</p>	D 255		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 255	<p>Continued From page 44</p> <p>10/2/17 at 2:29pm revealed:</p> <ul style="list-style-type: none"> -There was a bathing schedule for 1st and 2nd shifts. -Staff were expected to provide care based on residents' needs. -If there was a need for personal care assistance, she submitted a referral for a personal care assessment. -Whenever a resident refused a shower, the Personal Care Aide (PCA) was expected to report it to the Supervisor and the Supervisor reported continued refusals to the Resident Care Coordinator (RCC). <p>Interview with the Facility Owner on 9/29/17 at 4:21pm revealed:</p> <ul style="list-style-type: none"> -The facility's policy on personal care was based on residents' care plans. -Residents' personal care needs were identified by third party assessments (Liberty) for Personal Care Service levels. -If a resident had Licensed Health Professional Tasks (LHPS), then the facility staff incorporated that also into the residents' care plans. <p>Refer to Tag 188 10A NCAC 13F .0604(e)(1) Personal Care and Other Staff (Type B Violation)</p> <p>Refer to Tag 189 10A NCAC 13F .0604(e)(2) Personal Care and Other Staff (Type B Violation)</p>	D 255		
D 269	<p>10A NCAC 13F .0901(a) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision</p> <p>(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 45</p> <p>needs residents may be unable to attend to for themselves.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to provide personal care assistance such as incontinence care, bathing, grooming, and dressing for 3 of 5 sampled residents (#2, #15 and #17) resulting in Resident #17 becoming accustomed to lying on a urine saturated bed-sheet and incontinence pad; Resident #2 not being bathed for the month of September 2017; and Resident #15 having to find staff to ask for assistance with daily bathing, grooming, and dressing needs.</p> <p>The findings are:</p> <p>A. Review of current FL-2 dated 4/06/17 for Resident #17 revealed: -Diagnoses of skin disorders, amputated above knee, mental disorder, rheumatoid arthritis, circulatory disease, and gastro esophageal reflux. -Incontinent at times; wore "pull-ups." -Required extensive personal care assistance in the areas of bathing and dressing. -Ambulatory with wheelchair.</p> <p>Review of Resident Register revealed Resident #17 was admitted to the facility on 5/19/2015.</p> <p>Review of Care Plan dated 5/04/17 for Resident #17 revealed: -Resident #17 was ambulatory with a wheelchair. -Resident #17 required limited assistance from staff with bathing, grooming, and personal care.</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 46</p> <p>Review of Personal Care Notes dated 9/01/17 through 10/01/17 for Resident #17 revealed:</p> <ul style="list-style-type: none"> -The resident received bed baths. -Extensive assistance was required from staff for bed baths. -Extensive assistance was required from staff for hair care, skin care, and nail care. -Extensive assistance was required from staff for hygiene after toileting and incontinence. -Totally dependent on staff to clean urinal. -Limited assistance was required from staff for shaving. -Limited assistance was required from staff to assist resident to and from wheelchair. <p>Confidential Interview with a resident revealed:</p> <ul style="list-style-type: none"> -The residents went for days at a time wearing the same clothes. -The residents did not get a bath or shower. -Some of the residents smelled bad the majority of the time. -If a resident was a quiet or easy going, those residents were overlooked for grooming and bathing. -The few staff who worked at the facility were busy dealing with the residents who had behaviors. -Some of the residents would try and bathe on their own in the hall bathroom. -The resident bathed at the sink in the bathroom. -Sometimes a staff person would help but the resident had to ask for help. <p>Confidential interview with a second resident revealed:</p> <ul style="list-style-type: none"> -Residents rarely received a bath or shower. -A few residents had a strong body odor. -Some residents would wash up at the bathroom sink. 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 47</p> <ul style="list-style-type: none"> -The residents wore the same outfits three to four days in a row during the week. -Staff did the best they could but could not help every resident with bathing, grooming, and dressing. <p>Confidential interview with a third resident revealed:</p> <ul style="list-style-type: none"> -Staff would help the residents' bath or shower if they asked and had the time to do so. -Most residents got up and put on the same clothing as the day before. -Most of the residents' hair went uncombed and their faces unwashed for several days at a time. <p>Observation of Resident #17's room on 9/29/17 at 11:55-a.m. revealed:</p> <ul style="list-style-type: none"> -An extremely strong smell of urine and feces was evident from Resident #17's room door. -There was a soiled large incontinence pad on his bed. -The fitted and flat sheets were stained with dried urine and feces. -The pillowcase and pillow had dried yellowish brown stains. -The stain was dried on the outer perimeter and went from yellow to brown in color. -The full bedrail against the wall was in the up position. -A urinal was hung on the bedrail with a small amount of urine in it. -There was a medium sized white basket on the floor by the room entrance overflowing with dirty laundry. -A small pile of dirty laundry was on the floor by the medium sized white basket. -There were clothes piled on the chair and on the floor, that were also stained in the brown color. -There were empty plastic water bottles and soda cans on the window ledge. 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 48</p> <ul style="list-style-type: none"> -The window ledge was dirty. -The half bath in the resident's room had two small bars of soap that were dry on the soap dish on the counter by the sink. -There was a can of shave cream with dried grayish foam on the top of the dispenser. -There was an unopened two pack of toothbrushes on the counter by the sink. -There was a small wash basin turned over on the floor under the sink with a small plastic bin with a white lid placed on top of it. <p>Interview with the family member of Resident #17 on 9/29/17 at 11:57 a.m. revealed:</p> <ul style="list-style-type: none"> -The guardian was greatly concerned about the lack of personal care provided for his brother Resident #17. -Resident #17 had been there at the facility for 3 years now and he had requested a move for him because of the lack of personal care provided. -The resident's bed sheets are always left in urine and soil when he visits Resident #17. -He tried to change Resident #17's bed sheets, wash his clothes, and clean his room when he and his sister, Resident #17's secondary contact, visited every month or so. -Resident #17 was an amputee and needed staff to help him with bathing, grooming, dressing, cleaning his room, and incontinence care. -Whenever the resident went outside to smoke he would ask staff to change his sheets and incontinence pad. -Staff would tell him "hold on" while they were outside smoking cigarettes and would never go and change the bed sheets and incontinence pad. -Resident #17 said he asked staff last night (9/28/17 -9/29/17) to change his sheets and incontinence pad and they never did. -"The condition of my brother's room were 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 49</p> <p>"deplorable." -He knew his brother was "easy going but could be stubborn at times" but even so, no one should have to stay or live in conditions like this." -He brought his own cleaning supplies to clean his brother, Resident #17's, room. -Resident #17 has to go find staff when he needs help. -He and Resident #17's sister had contacted the Clinical Operations Manager, but had not received a response. (He was unable to specify the number of times).</p> <p>Observation of Resident #17's room on 10/02/17 at 2:00 p.m. revealed: -A strong smell of urine and feces was evident from Resident #17's room door. -There was a soiled large incontinence pad on his bed. -The fitted and flat sheets were stained with dried urine and feces. -The pillowcase and pillow had dried yellowish brown stains. -The stain was dried on the outer perimeter and went from yellow to brown in color. -A urinal was hung on the bedrail with a small amount of urine in it. -There was a medium sized white basket on the floor by the room entrance covered with a small white towel with dirty laundry. -The window seal was dirty.</p> <p>Interview with Resident #17 on 10/02/17 at 2:08 p.m. revealed: -Staff checked on him today, but the resident stated, "Do you see anybody?" -Staff did come and help him with incontinence care at bedtime, but that was it. -Staff did not check on him through the night or during the day.</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 50</p> <ul style="list-style-type: none"> -When staff come to check on him, he allowed them to help him and did not refuse. -He had to lay on his bed when it was wet and soiled because he had no choice. <p>Interview with staff from the Nurse Practitioner (NP) of Resident #17 on 10/02/17 at 9:50 a.m. revealed:</p> <ul style="list-style-type: none"> -In January 2017, the facility ordered a hospital bed for the resident. -Resident #17 was an amputee and should be in a wheelchair. -The resident's bed sheets should be changed if they were soiled. -The NP's office were not aware of the condition of Resident #17's room, his bed sheets not being changed, or of any personal care issues. -The resident was seen in the doctor's office and not onsite at the facility. <p>Interview with the second family member of Resident #17 on 10/02/17 at 10:48 a.m. revealed:</p> <ul style="list-style-type: none"> -The condition of Resident #17's room was "terrible!" -She had to clean Resident #17 up, change his bed, and wash his clothes when she came to visit. -Staff were busy taking care of other residents when she visited so she attended to her brother Resident #17. -She had contacted the facility, Clinical Operations Manager, but had heard back from her. -The condition of Resident #17's room had been that way since he had been admitted to the facility. -Her brother needed assistance with taking care of himself because he was an amputee and in a wheelchair. 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 51</p> <p>Interview with a Personal Care Aide (PCA) on 10/2/17 at 1:21 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #17 did not take showers because he feared staff would drop him. -She did not know if the resident had ever been dropped before. -Resident #17 would get sponge baths on his showers days. -She had done Resident #17's laundry last Wednesday (9/27/17) and she had not checked the resident's laundry on 10/2/17. -Resident #17 did not complain, if staff asked him if he needed his bed changed the resident would say if you want to. -Staff checked Resident #17 every two hours for incontinence. -Resident #17 would tell staff if he needed to be changed and on certain days the resident might "be in a mood," come find staff and say "you haven't checked on me and I need to be changed." <p>Interview with the Clinical Operations Manager (COM) and Administrator on 10/2/17 at 2:39 p.m. revealed:</p> <ul style="list-style-type: none"> -The COM was aware of the condition of Resident #17's room on 9/29/17, but not on 10/2/17 at 2:00pm. -The Administrator was not aware of the condition of Resident #17's room. -Anytime Resident #17 had an issue he would come to the COM and he had not reported any concerns to the COM in "quite some time" meaning at least a month. -Resident #17 usually reported not getting a shower. -The 3rd shift was the only shift that documented every two-hour incontinence checks on residents, 1st and 2nd shift documented on resident checks on the personal care records. 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 52</p> <p>-The facility checked residents for incontinence a minimum of every two hours 24 hours a day and linens were change three times a week and when soiled.</p> <p>B. Review of Resident #15's FL2 dated 6/15/17 revealed: -Diagnoses included dementia secondary to Parkinson's, chronic obstructive pulmonary disease, osteoarthritis and hypothyroidism. -Her disorientation was documented as "constantly disoriented." -Her personal care assistance was documented as bathing, feeding and dressing.</p> <p>Review of Resident #15's Care Plan dated 6/27/17 revealed: -She required total assistance with eating and bathing. -She required limited assistance with toileting, dressing and grooming. -She required supervision with ambulation and transfer. -She ambulated with a rolling walker and needs reminders.</p> <p>Review of Resident #15's Licensed Health Professional Support (LHPS) dated 6/23/17 revealed: -She was to ambulate with assisted devices. -She was recently upgraded to Skilled Nursing Facility (SNF) by the Primary Care Provider on 6/15/17 and seeking placement.</p> <p>Observations on 9/25/17 at 10:45 a.m. through 4:45 p.m. revealed: -Resident #15 was walking outside the facility with a rollater. -Resident #15 had a hunched stature, slow and limping gait and significant hand tremors.</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 53</p> <p>-Resident #15's hair was dissheveled and uncombed. -Resident #15's clothing was ill-fitting and dirty.</p> <p>Interview with Resident #15 on 9/25/17 at 10:45 a.m. revealed: -She had Parkinson's disease and getting dressed presented a challenge. -Staff helped, but "you just have to go and find them." -Staff did not check on her routinely to offer assistance. -She was unsure of the last time she received a shower. -She needed staff to help her get bathed, groomed, and dressed but they were always busy helping other residents. -She didn't want to be a bother but she shook a lot and getting ready was difficult.</p> <p>Telephone interview on 9/28/17 at 3:00 pm with Resident #15's Primary Provider revealed: -He had upgraded Resident #15 to SNF because of supervision because of her dementia. -He received a note from the facility dated 7/11/17 stating Resident #15 had not fallen or had issues since admitted to the facility on 6/14/17 and requested a downgrade and order written to remain at the facility. -He was aware Resident #15 fell, hit her head and was sent out to the ER. -He feels Resident #15 would benefit from a more secure environment with increased supervision, wound care and overall assistance.</p> <p>Attempted interview with designated contact person on 9/28/17 at 6:00 p.m. was unsuccessful.</p> <p>Refer to confidential interview with a resident.</p>	D 269		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 54</p> <p>Refer to observations on 9/25/17 at 9:20 a.m. through 10/2/17 at 6:00 p.m..</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30 a.m.</p> <p>Refer to interview with a Medication Aide (MA) on 10/2/17 at 12:41 p.m.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23 p.m.</p> <p>Refer to interview with the Operations Manager (OM) on 10/2/17 at 2:29 p.m.</p> <p>Refer to interview with the Owner on 9/29/17 at 4:21 p.m.</p> <p>C. Review of Resident #2's current FL-2 dated 5/31/17 revealed: -Diagnoses included Major Depression with Suicidal Ideations. -Resident #2 was ambulatory, continent of bowel and bladder and needed assistance with bathing.</p> <p>Review of Resident #2 current care plan dated 10/19/16 revealed: -Staff documented Resident #2 was admitted to the facility in October 2016 and came from a skilled nursing facility. -Resident #2 had several strokes with resulting communication difficulties. -Resident #2 was able to say "yes, no and a few other simple words" and staff needed to "listen carefully and observe body language to understand" the resident. -Resident #2 had no problem ambulating, was</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 55</p> <p>independent with toileting, bathing, dressing and required supervision with meals.</p> <p>Review of Licensed Health Professional Support (LHPS) evaluation for Resident #2 dated 10/25/16 revealed:</p> <ul style="list-style-type: none"> -Resident #2 was ambulatory with a cane and was able to give yes/no answers. -Resident #2 was being followed by Physical Therapy for gait and mobility. -There were no other LHPS tasks and staff should notify the LHPS Nurse if there were any additional LHPS tasks identified. -The form was signed as reviewed by the Resident Care Coordinator (RCC) on 10/26/16. <p>Observation on 9/25/17 at 10:32am revealed:</p> <ul style="list-style-type: none"> -Resident #2 entered the smoking area outside from the entrance near the facility's medication room. -Resident #2 propelled the wheelchair forward using his left foot and left hand. -Resident #2 was in a wheelchair with a ball cap, black and gray jacket, blue T shirt and blue jeans on. -The left pant leg had a tannish/brown stain on the thigh area. -Resident #2 had a gob of phlegm on his beard. -Resident #2's left hand nails were approximately an eighth of an inch in length and had a black substance built up under each nail. -Resident #2's was unable to move his right arm except to pick the arm up with his left hand. <p>Interview with the RCC on 9/29/17 at 6:23pm revealed:</p> <ul style="list-style-type: none"> -She did not know the exact date, but Resident #2 had been in a wheelchair since the PCP wrote the order. -Resident #2 had a care plan assessment done 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 56</p> <p>9/17/17, but it was not completed yet because the Operations Manager (OM) needed to complete the first page of the care plan.</p> <ul style="list-style-type: none"> -Resident #2's Primary Care Provider (PCP) had already signed the new care plan. -Resident #2 was ambulatory with a cane when he was admitted to the facility. -She had some updated LHPS evaluations on her desk, but did not have one for Resident #2. -Resident #2 had "his days he refused" showers for nonspecific reasons, just the mood he was in. <p>Review of a PCP visit note for Resident #2 dated 6/1/17 revealed:</p> <ul style="list-style-type: none"> -Under "Plan," the PCP documented "manual wheelchair, diagnosis gait disturbance secondary to Cerebral Vascular Accident." -The visit note was signed by the PCP. <p>Review of the "unfinished" care plan for Resident #2 dated 9/21/17 revealed:</p> <ul style="list-style-type: none"> -The first page was not filled out. -The second page indicated Resident #2 was ambulatory with a wheelchair, had no problems with his upper extremities and had normal speech. -The third page indicated Resident #2 required supervision with meals; and limited assistance with ambulation, bathing, dressing and grooming. <p>Observations on 9/26/17 at 6:02am and 11:50am revealed:</p> <ul style="list-style-type: none"> -Resident #2 was in a wheelchair in the common area near the medication room. -Resident #2's beard was clean, the resident's nails on his left hand still had the black substance built up and his clothes were unchanged from 9/25/17 at 10:32am. <p>Observations on 9/26/17 at 5:10pm revealed:</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 57</p> <ul style="list-style-type: none"> -Resident #2 was in a wheelchair in the 300 hallway common area. -Resident #2's nails on his left hand still had the black substance built up under each nail. -Resident #2 had the same jeans with the tannish/brown stain on the left thigh area, but had on a white T shirt. <p>Observations on 9/27/17 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was in a wheelchair in the common area. -Resident #2's nails on his left hand still had the black substance built up under each nail. -Resident #2 had the same jeans with the tannish/brown stain on the left thigh area, and the white T shirt which had a few dime and nickel sized tan/yellow spots on the right chest area. <p>Observations on 9/28/17 at 9:50am revealed:</p> <ul style="list-style-type: none"> -Resident #2 was in the smoking area outside from the entrance near the facility's medication room. -Resident #2's nails on his left hand still had the black substance built up under each nail. -Resident #2 had the same jeans with the tannish/brown stain on the left thigh area, and the white T shirt which had a multiple dime and nickel sized tan/yellow spots on the right chest area and the abdomen. <p>Interview with Resident #2 on 9/28/17 at 9:50am revealed:</p> <ul style="list-style-type: none"> -Do the staff help you shower and dress? The resident responded "No." -Do the staff offer to help you? The resident responded "No." -Do you refuse staff help to shower and dress? The resident responded, "No." <p>Interview with a Personal Care Aide (PCA) on</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 58</p> <p>10/2/17 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -There were four residents who needed baths every day, the rest of the residents were showered one day and sponged bathed the next day. -There was a shower list in the staff break room and the PCAs divided the list each shift amongst themselves. -The shower list was divided differently depending on who she was working with; some days it may be divided by males or females and other days by hall. -She was usually "the one" who could get Resident #2 to shower, but the resident refused to let her bathe him. -Usually when Resident #2 refused, his family member would come and help with his shower. -When a resident refused a shower she reported it to the Supervisor. -The Supervisor then goes and tries to get the resident to take a shower. -The PCAs document on the deviation sheet when residents refuse personal care. <p>Review of the shower schedule revealed Resident #2 was to receive a shower on 2nd shift on Monday, Wednesday and Friday.</p> <p>Review of Resident #2's Personal Care Record and "Deviation Report" for September 2017 revealed:</p> <ul style="list-style-type: none"> -There was documentation that Resident #2 required extensive assistance with bathing. -Staff documented Resident #2 refused bathing 9/1/17 through 9/27/17 on his Personal Care Record. -On 9/26/17 and 9/27/17 the same staff documented Resident #2 refused "all personal care" on the Deviation Report. 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 59</p> <p>Interview with a Medication Aide (MA) on 9/28/17 at 10:28am revealed: -Resident #2 stayed to himself and spent his time either outside or watching TV. -Resident #2 was able to feed himself and toilet himself. -Staff assisted Resident #2 with showers and grooming. -The pharmacy nurse completed LHPS assessments.</p> <p>Interview with a second MA on 10/2/17 at 12:41pm revealed: -Resident #2 refused showers a lot. -She was not aware that he had refused 9/1/17 through 9/27/17. -She was aware that there were only two entries on the deviation sheet for 9/26/17 and 9/27/17 that Resident #2 had refused his shower. -The PCAs were supposed to let the MAs know when a resident refused a shower, but "obviously some things fall through the cracks."</p> <p>Telephone interview with Resident #2's Primary Care Provider (PCP) on 9/28/17 at 4:35pm revealed: -Resident #2 "needed quite a bit of assistance with bathing and dressing for sure." -Resident #2 was able to stand and transfer. -Right now Resident #2 was "OK" in the assisted living setting, but if the resident continued to decline, he would need to be evaluated for skilled nursing care.</p> <p>Telephone interview with Resident #2's Mental Health Provider (MHP) revealed: -She would see Resident #2 monthly at the facility. -She had not noticed any concerns with bathing or hygiene.</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 60</p> <p>-Staff had mentioned Resident #2 refused to shower once, but "then he took a shower and that was it." -She did not recall when that was off hand.</p> <p>Interview with the Operations Manager (OM) on 10/2/17 at 2:29pm revealed: -Staff may have a hard time with showering Resident #2 because he was nonverbal and difficult to understand. -Resident #2 went through "spells" of not wanting to take a shower. -She was not aware that Resident #2 refused to shower 9/1/17 through 9/27/17. -Whenever a resident refused every day like that, the refusals were supposed to have been reported to her. -She expected staff to offer hand washing before meals especially when a resident refused showers. -Both she and the PCAs did nail care for residents.</p> <p>Refer to confidential interview with a resident.</p> <p>Refer to telephone interview with a family member on 10/2/17 at 10:54am.</p> <p>Refer to observations on 9/25/17 at 9:20am through 10/2/17 at 6:00pm.</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am.</p> <p>Refer to interview with a Medication Aide (MA) on 10/2/17 at 12:41pm.</p> <p>Refer to interview with the Resident Care</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 269	<p>Continued From page 61</p> <p>Coordinator (RCC) on 9/29/17 at 6:23pm.</p> <p>Refer to interview with the Operations Manager (OM) on 10/2/17 at 2:29pm.</p> <p>Refer to interview with the Owner on 9/29/17 at 4:21pm.</p> <hr/> <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> -On the 3rd shift, the facility smelled like urine and feces because resident who needed to be changed were not changed all night. -Residents who had not been changed would come into the dining room and sit down for breakfast "reeking of urine and feces" while other residents were trying to eat. -There were residents who walked around the facility in the same clothes for three and four days in a row: <p>Telephone interview with a family member on 10/2/17 at 10:54am revealed:</p> <ul style="list-style-type: none"> -The facility did not provide good care and services for the residents. -Whenever the family visited the facility, there were residents with "pissy clothes and pissy rooms." -Resident did not get their nails cut or their hair cut. -The family member had discussed concerns with the Operations Manager (OM) on several occasions. <p>Observations on 9/25/17 at 9:20am through 10/2/17 at 6:00pm revealed there was a resident of color with a white beard and a salt and pepper afro who had on the same clothes (a blue green and white soccer jersey type shirt with light tan carpenter style pants) for eight days.</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 62</p> <p>Confidential interview with a staff revealed: -Staff was concerned that residents should not be treated like they were being treated. -Staff was in and out of a lot of residents' rooms during 1st shift and noticed that if residents were quiet and stayed to themselves they were "overlooked" by staff. -Those residents would not get help with their personal hygiene like showers and getting their nails trimmed. -The staff were always busy dealing with residents who were fighting and manipulating the staff to get the cigarettes and soda the residents wanted. -There were not enough staff to take care of the residents.</p> <p>Interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am revealed: -She worked 1st shift and usually arrived early to work to see if 3rd shift staff needed help. -All of the PCAs on duty each day were responsible for all of the residents. -Residents were not assigned to a particular PCA for showers; halls were not assigned to any particular PCA either. -The PCAs knew which residents needed shower and toileting assistance based on what was in the PCS (Personal Care Services) book. -The PCS book had the residents who received the 80 hours of personal care services such as bathing, toileting, dressing and help with transfers. -There were approximately 30 residents receiving PCS assistance in the facility. -There was a deviation page with each residents PCS record. -Staff documented any resident refusals to shower, refusals to be shaved if the resident was</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 63</p> <p>a man and refusals to eat.</p> <ul style="list-style-type: none"> -The PCAs on duty communicated with each other to know who had done what for each resident and worked as a team. -She was not aware of any residents in particular who were difficult to bath or gave staff a hard time about bathing. <p>Interview with a Medication Aide (MA) on 10/2/17 at 12:41pm revealed:</p> <ul style="list-style-type: none"> -There was a bathing schedule posted in the staff break room where residents were assigned showers for 1st or 2nd shift. -If the resident had an incontinence episode and needed bathing, they would be bathed. -The PCA's were supposed to let the MAs know if a resident refused to bath or shower. -She "really did not have an explanation for" Resident #17 and the condition of his room and bed on 9/29/17. -The PCAs worked together and chose which residents they were going to shower each shift. -If the PCAs were unable to choose themselves, then the MAs would assign resident to shower to each PCA on duty. <p>Interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm revealed:</p> <ul style="list-style-type: none"> -There was a bathing schedule posted in the staff break room. -If a resident refused a shower, the personal Care Aide (PCA) let the medication room staff (MAs) know. -The medication room staff usually tried to get the resident to take a shower. -If the resident continued to refuse that was their right. -Staff would try giving an as needed medication for some residents to help with showers. -The next shift would also try to give showers for 	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 64</p> <p>any resident that had refused.</p> <p>-A lot of the time, the PCAs would split the showers for the shift and other times one PCA might get the showers done while the other PCA does other tasks.</p> <p>-Some staff were good at getting the showers done.</p> <p>Interview with the Operations Manager (OM) on 10/2/17 at 2:29pm revealed:</p> <p>-There was a bathing schedule for 1st and 2nd shifts.</p> <p>-Staff were expected to provide care based on residents' needs.</p> <p>-If there was a need for personal care assistance, she submitted a referral for a personal care assessment.</p> <p>-Whenever a resident refused a shower, the Personal Care Aide (PCA) was expected to report it to the Supervisor and the Supervisor reported continued refusals to the Resident Care Coordinator (RCC).</p> <p>Interview with the Owner on 9/29/17 at 4:21pm revealed:</p> <p>-The facility's policy on personal care was based on residents' care plans.</p> <p>-Residents' personal care needs were identified by third party assessments (Liberty) for Personal Care Service levels.</p> <p>-If a resident had Licensed Health Professional Tasks (LHPS), then the facility staff incorporated that also into the residents' care plans.</p> <p>Refer to Tag 188 10A NCAC 13F .0604(e)(1) Personal Care and Other Staff (Type B Violation)</p> <p>Refer to Tag 189 10A NCAC 13F .0604(e)(2) Personal Care and Other Staff (Type B Violation)</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 269	<p>Continued From page 65</p> <p>The facility's failure to assure the personal care needs of the residents were met daily resulted in residents' being ungroomed, having offensive body odors, having an un-kept appearance, and wearing dirty, ill-fitting clothing for days at a time as evidenced by the facility's inadequate response to the incontinence care, grooming, and bathing needs of residents. This failure is detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <hr/> <p>Review of the Plan of Protection submitted by the facility on 9/29/17 revealed: -The facility will provide and monitor the personal care needs of the residents daily to ensure compliance. -The OM or designated management staff will communicate with the designated mental health provider regarding any changes in behavior or treatment/care plans to assure the facility is in compliance.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2017</p>	D 269		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 66</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 4 of 9 sampled (#16, 18, 9, and 6) residents in accordance with the residents' assessed needs and current symptoms as evidenced by: allowing Resident #16 to ingest hand sanitizer and mouthwash with a known history of alcohol abuse and hospitalizations related to the ingestion of those products; Resident #18 eating out of the trash with a known history of this behavior, and knowledge other residents having Hepatitis C; Resident #9 frequently smoking inside the building and wandering into other residents' rooms and stealing; and Resident #6 who had a history of violent outbursts with threats to staff and other residents resulting in hospitalizations for involuntary commitment, with symptoms of escalating aggression since mid September 2017 and no evidence of monitoring for safety.</p> <p>The findings are:</p> <p>A. Review of Resident #16's current FL2 dated 4/06/17 revealed diagnoses including asthma, ETOH (alcohol) disorder, schizoaffective disorder, and bipolar disorder.</p> <p>Review of Resident #16's care plan dated 5/18/17 revealed: -She required minimal assistance with eating, bathing and grooming and independent with toileting, ambulation, dressing and transfers. -She was to be supervised on outings so that she did not buy products containing alcohol (meaning her bags were to be searched after getting out of the store).</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 67</p> <p>-Staff was to report to Resident #16's physician if the staff observed alcohol related behaviors.</p> <p>Review of Resident #16's Accident/Injury Reports revealed: -A report dated 5/17/17 at 10:30 pm documented she had slurred speech and drank 2 bottles of mouthwash. -A report dated 5/28/17 at 5:00 pm documented she was angry and drank a bottle of mouthwash. -A report dated 9/07/17 at 8:30 pm documented she had slurred speech and had been drinking hand sanitizer with another resident. -A report dated 10/01/17 at 7:30 pm documented she had slurred speech and had been drinking hand sanitizer. A breathalyzer performed by law enforcement documented her breath alcohol level as .20 (0.16 is significant intoxication and 0.30 is severe intoxication) and was transported to jail by the local sheriffs department.</p> <p>Review of Resident #16's Nurses Notes revealed: -A note dated 5/17/17 11:15 pm documented Resident #16 was intoxicated, smelled of mouthwash and handed staff 2 empty 16.9 oz bottles of mouthwash. The doctor was called and so was poison control and she was to be put on every 15 minute checks. -A note dated 5/29/17 at 12:18 am documented a Medication Aide (MA) received report from the 2nd shift Supervisor, Resident #16 signed out of the facility and bought and drank mouthwash. Resident became "intoxicated, agitated and physically aggressive with other residents and staff". Law enforcement and the local emergency medial services were called. Resident #16 was taken to hospital and admitted. -A note dated 6/04/17 at 5:51 am documented Resident #16 returned from the hospital after being taken there involuntary but did not continue</p>	D 270		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 68</p> <p>to meet the criteria and did seem to return quickly to her baseline. Management of the facility discussed possible discharge if Resident #16 did not comply with the facility rules. Resident #16 understood and promised to discontinue recent behaviors.</p> <p>-A note dated 10/02/17 at 12:02 am documented Resident #16 "had slurred speech", 911 was called, mental health was called and Resident #16 was transported to jail.</p> <p>-A note dated 10/02/17 at 10:06 am documented Resident #16 was issued a 30 day discharge, and an appeal was requested by Resident #16, and the facility would continue to try to reach the mental health provider.</p> <p>-A note dated 10/02/17 at 10:58 am documented speaking with Resident #16's mental health provider to inform of incident, and a treatment team meeting (to discuss the incident and options) was scheduled for Wednesday (no date) at 11:30 am for further discussion of the discharge notice.</p> <p>Review of Resident #16's Supervision Assessment dated 4/18/16 completed by the mental health provider revealed:</p> <p>-It was documented, "Standard supervision was adequate [every 2 hours] with added 15 minute checks if concerns of self or others".</p> <p>-Standard supervision documented two-hour checks that all residents were present in the facility, if risk behavior was noted, they were to follow the crisis plan, if resident was believed to be in danger they were to call the local law enforcement, the guardian, the Department of Social Services, the mental health provider, and the primary care provider and keep them updated as appropriate given the situation, and follow mental health providers' recommendations regarding ongoing supervision and update care</p>	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2017
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D 270 Continued From page 68

plan as necessary.

- There was no supervision assessment dated after 4/18/16.

Review of Resident #16's 15 minute checks revealed:

- There was no documentation of 15 minute checks of Resident #16 on 5/17/17 after she consumed two bottles of mouth wash.
- There was no documentation of 15 minutes checks of Resident #16 on 5/28/17 after she consumed another bottle of mouthwash.
- There was no documentation of 15 minutes checks of Resident #16 on 9/01/17 after she consumed a bottle of hand sanitizer.
- There was documentation of 15 minute checks on Resident #16 on 10/01/17 at 7:15 pm until 8:30 pm at which time Resident #16 was in custody of the local law enforcement.
- The 15 minute checks resumed upon her return from jail on 10/01/17 at 4:45 am and the checks continued until 10/02/17 at 1:45 pm.

Review of Resident #16's Mental Health Crisis Prevention & Intervention Plan dated 3/31/17 revealed:

- Diagnoses were documented as schizoaffective disorder, bipolar type, and severe alcohol and tobacco use.
- It was documented to call the mental health provider or staff for issues or problems.

Review of Resident #16's Mental Health Action Plan dated 3/31/17 revealed:

- It was documented Resident #16, "refused meds a lot", "paranoid" and "fighting", and "craving alcohol".
- Resident #16's goals were documented as: "consistently engage in treatment", "adhere to medication regimen", "review, practice and use

D 270

- Any resident who exhibits severe substance abuse behaviors will be referred to a mental health provider, with explanation of the behavior observed. The facility will follow up with mental health provider and follow actions recommended by the resident's mental provider. If a resident, exhibits severe substance abuse behaviors, the facility will meet regularly with their mental health provider and participate in "treatment team meetings" which include the mental health provider, facility management, and the resident to fully communicate and help motivate resident to suspend their substance abuse behaviors.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 70</p> <p>crisis care plan as needed", "ask for help", "practice sobriety, work to increase boundaries on triggers and access to alcohol", and " addressing substance use issues with staff and mental health providers".</p> <p>Review of Resident #16's Mental Health visit notes revealed: -A noted dated 5/24/17 documented Resident #16 "drinking mouth wash to get drunk", irritable, inability and poor decision making, and to continue plan. -A note dated 5/31/17 documented Resident #16 "drinking mouthwash to get drunk", "a little manic, could angry quickly, somewhat labile", "delusions", and medication changes. -A note dated 7/12/17 documented Resident #16 doing better and continue plan. -A noted dated 8/09/17 documented Resident #16 "drinking hand sanitizer", "extreme anger swings", "irritable with auditory hallucinations and delusions", labs drawn and medications increased.</p> <p>Review of Resident #16's Hospital Emergency Room (ER) notes dated 9/07/17 revealed: -An admission date of 9/07/17 at 9:54 pm. -The reason for ER visit documented as "ingestion of a bottle and a half of hand sanitizer" and "trying to get drunk". -Resident #16 was discharged back to facility and documented instructions to follow up with doctor as needed.</p> <p>Interview on 9/28/17 at 11:33 am with Resident #16 revealed: -She had an altercation 2 months ago with another resident and was involuntarily committed and spent 2 weeks in the hospital related to drinking hand sanitizer.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 71</p> <ul style="list-style-type: none"> -She had been caught drinking mouthwash 2 times in May 2017 and drank hand sanitizer in August and 2 times in September 2017. -She switched to the hand sanitizer in August because the staff could not "smell" it on her breath as easy". -She "like the taste" of both of the products. -She could sign herself out at any time without restrictions. -The facility staff checked all of her bags when she went shopping with them, which was the only way she was able to go to the store unless the mental health team took her. -Other residents bought things for her, including mouth wash and hand sanitizer, at the store and their bags were not searched. -There was an occasion she purchased the hand sanitizer when she went shopping with the mental health provider. -The facility was aware the mental health team was with her when she purchased hand sanitizer and did not check her bag and neither did the facility. -She was told by the doctor and the facility after the second time to stop drinking the mouthwash and hand sanitizer or she would be discharged. <p>Observation on 9/28/17 at 11:33 am of a resident handing a shopping bag to Resident #16 that he purchased for her during our interview.</p> <p>Record review revealed a medication order change dated 8/9/17 to increase Resident #16's order for naltrexone 50mg, 1 tablet daily to naltrexone 50mg, 2 tablets daily (naltrexone is a medication used to treat addictions and reduce cravings).</p> <p>Interview on 9/28/17 at 12:15 pm with a resident revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 72</p> <ul style="list-style-type: none"> -He often bought coffee, drinks and food for Resident #16. -The facility did not check his bags when he returned from the store at any time. -He had never bought mouth wash or hand sanitizer for Resident #16. -The facility only completed room searches if they were looking for "weed". -The staff searched bags only if you went to the store by van. -He walked to the store for many residents and purchased drinks, food, cigarettes, etc. <p>Review of Resident #16's Primary Care Providers notes revealed a note dated 9/21/17 documented "drinking hand sanitizer" and to "D/C her for drinking hand sanitizer again!".</p> <p>Telephone interview on 9/28/17 at 3:00 pm with Primary Care Provider revealed:</p> <ul style="list-style-type: none"> -He was aware of the 9/07/17 incident regarding her ingestion of the hand sanitizer and recommended discharging Resident #16 but Resident #16 and the staff assured him the incident would not happen again. -Resident #16 was seen in the office on 9/07/17 and 9/21/17 about drinking hand sanitizer. -He felt Resident #16 would benefit from a more secure environment with increased supervision. -The physician expected the staff supervise Resident #16 closely and report any issues with ingesting mouthwash, hand sanitizer or any other alcohol based liquids. -The risks of drinking products containing alcohol included; Liver and kidney damage, esophageal varices, and ulcers even death if the above were not treated. -He considered this a significant risk to Resident #16's health and well being, including death. -He also considered this to be a risk to the other 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 73</p> <p>residents and staff due to the increase in violent behaviors Resident #16 exhibited after consuming alcohol.</p> <p>Interview on 9/28/17 at 4:43 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -Resident #16 required 15 minute checks only if there had been an issue for a total of 72 hours. -Resident #16 was her own responsible person and would sign herself out to leave the building. -Resident #16's bags were searched when with staff on a shopping trip. -On 9/07/17, Resident #16 was with the mental health team shopping and purchased hand sanitizer and drank it at the facility. -She spoke with the mental health team after that the 9/07/17 incident and Resident #16 was not allowed to purchase mouthwash or hand sanitizer anymore. -Resident #16 told her the mouthwash and hand sanitizer was acquired by her and once by her boyfriend (not a resident at the facility). -She was aware that another resident bought stuff for her at the store but not searched those bags because "it was not an issue". -The staff was to report any suspicions of intoxication to her or the Resident Care Coordinator (RCC) and would be investigated. -Discharge was discussed with Resident #16 several times but she was reassured by Resident #16 she would comply with the rules of the facility. <p>Attempted telephone interview with Mental Health provider on 10/02/17 at 11:18am was unsuccessful.</p> <p>Attempted telephone interview with the Mental Health Crisis line on 10/02/17 at 11:19am and 11:21am was unsuccessful.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 74</p> <p>Interview with a Personal Care Aide (PCA) on 10/2/17 at 11:05am revealed: -About 2 weeks ago, Resident #16 and another resident drank hand sanitizer. -When Resident #16 went out with her mental health worker, the mental health worker or the Medication Aide or supervisor were supposed to check her bags.</p> <p>Interview with a second PCA on 10/2/17 at 12:15pm revealed: -Three residents were identified as ingesting hand sanitizer last night (10/1/17) including Resident #16. -Someone (not identified) took Resident #16 shopping and did not check her bag. -The "activity lady" or Medication Aide would have checked the the resident's bags.</p> <p>Interview on 10/02/17 at 12:05 pm with a Medication Aide (MA) revealed: -She primarily worked 1st shift and at least 2 times a month on 3rd shift. -She rarely noticed behavioral issues on 1st shift. -In her opinion the behavioral issues were on 2nd shift primarily and some on 3rd. -She was aware of Resident #16 drinking mouthwash and hand sanitizer and monitored Resident #16 for suspicious behaviors. -When Resident #16 returned from the store either by van or walking, all of Resident #16's bags were to be searched when she got in the van or upon entry to the facility. -There were to be 15 min checks on all residents for 72 hours after returning from the hospital, new admissions, or after behavioral issues documented in the frequent checks book located in the MA room. -Personal Care Aides (PCA) were responsible for</p>	D 270		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 75</p> <p>doing all 15 minute checks.</p> <p>-A MA does not need an order from the doctor to put a resident on 15 minute checks.</p> <p>-All issues or negative behaviors were documented on the supervisor shift report located in the electronic Medication Record (eMAR) for the Administrator to review.</p> <p>-At shift report she was informed about any incidents from the previous shift and the MAs were responsible for checking to see that the supervision was completed. "We all supervise".</p> <p>-She looked at the crisis plans that were filled out by the mental health provider on all residents with mental health issues and reviewed them monthly for changes(i.e. new behaviors or residents acting out).</p> <p>-She was not aware who monitored the plans for changes or to ensure they were current.</p> <p>Interview with a third Personal Care Aide (PCA) on 10/2/17 at 1:21pm revealed:</p> <p>-She was not aware that Resident #16 had recently drank hand sanitizer.</p> <p>-Resident #16 had an incident when the resident went out with a case worker and got some mouthwash or hand sanitizer and drank it.</p> <p>-The resident was sent to the emergency room for that incident and then placed on one to one with facility staff on any outings.</p> <p>Refer to observation inside the medication room on 9/26/17 at 11:55am.</p> <p>Refer to interview with the Owner on 10/2/17 at 5:55pm.</p> <p>Refer to observation on 10/2/17 at 6:00pm.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 76</p> <p>Refer to interview with a second PCA on 9/26/17 at 6:16am.</p> <p>Refer to interview with a third PCA on 10/2/17 at 1:21pm.</p> <p>Refer to interview with a MA on 9/28/17 at 10:28am and 10/2/17 at 12:41pm.</p> <p>Refer to interview with the Mental Health Treatment Team Nurse (MHFTN) on 9/29/17 at 9:50am.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm.</p> <p>Refer to interview with the Owner on 9/29/17 at 7:30pm and 10/2/17 at 5:15pm.</p> <p>B. Review of Resident #18's current FL2 dated 3/02/17 revealed diagnoses included alcohol abuse, cannabis abuse, and schizophrenia.</p> <p>Review of Resident #18's care plan dated 11/02/16 revealed he required minimal assistance with eating and had no recent psychiatric hospitalizations.</p> <p>Observation on 9/28/17 at 11:40 am of Resident #18 revealed half of his body in the trash can in the dining room, eating garbage. His face was covered with egg and crumbs. There were no staff in the kitchen or dining room.</p> <p>Observation on 9/28/17 at 12:10 of Resident #18 revealed he was in the trash in the dining room and pulled out a plastic cup of unknown fluid and drinking it.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 77</p> <p>Observation on 10/02/17 at 11:56 am revealed the dining room trash was ½ full of breakfast food.</p> <p>Observation on 10/02/17 at 12:00 pm revealed Resident #18 eating out of the trash.</p> <p>Observation on 10/02/17 at 1:50 pm revealed the dining room trash was ¾ full with food and trash. There was no staff in the kitchen or dining room.</p> <p>Observation on 10/02/17 at 1:55 pm revealed Resident #18 was eating out of the dining room trash.</p> <p>Interview with Resident #18 on 10/02/17 at 1:55 pm revealed he was hungry.</p> <p>Interview on 10/02/17 at 1:56 pm with a Medication Aide revealed she would write a note for the facility operation manager and "it would be handled".</p> <p>Observation on 10/02/17 at 2:00 pm revealed the dining room trash was ¾ full with food and trash. No staff was in the kitchen or dining room.</p> <p>Interview on 9/28/17 at 11:46 am with Resident #18 revealed: -He ate out of the trash all of the time. -He "did not get breakfast" and was hungry. -He did not see anything wrong with eating out of the trash.</p> <p>Review of Resident #18's Accident/Injury Reports revealed no reports filed as of 10/02/17 at 2:00 pm.</p> <p>Review of Resident #18's Nurses Notes revealed: -A note dated 7/03/17 at 9:39 am documented</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 78</p> <p>Resident #18 "was caught digging in the trash, and staff redirected him" -A note dated 7/23/17 at 11:21 am documented Resident #18 "refused his meal and had been caught digging in the trash, and staff had talked to him about this a he continued to do it". -A note dated 8/11/17 at 9:42 am documented Resident #18 "refused his meal and had been digging in the trash and the staff had spoken to him about it a few times". -A note dated 9/12/17 at 11:34 am documented Resident #18 had "been seen going through the trash looking for food". -A note dated 9/13/17 at 10:35 am documented Resident #18 "continues to eat out of the trash and refused meals served and management knows about this". -There were no other notes documented after 9/13/17 at 10:35 am until 10/02/17 at 2:00 pm.</p> <p>Review of Resident #18's Record revealed: -There were no documented 15 minute checks as of 10/02/17 at 2:00 pm. -There was no documented Supervision Assessment completed by the mental health provider as of 10/02/17 at 2:00 pm. -There was no documented Mental Health Crisis Prevention & Intervention Plan as of 10/02/17 at 2:00 pm.</p> <p>Review of Resident #18's Mental Health visit notes revealed a note dated 9/27/17 documented Resident #18 "had been tearing his clothes more lately, and skipping meals, preferring to scavenge in the trash for food. Will monitor behaviors".</p> <p>Observation on 09/28/17 at 11:50 of outside kitchen trash area revealed 5 large gray bags of trash.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 79</p> <p>Interview on 9/28/17 at 11:50 am with a resident revealed: -He helped take care of the trash by taking the bags of trash behind the kitchen to the dumpster. -The dining room trash was to be emptied after every meal. -Resident #18 was just in the garbage behind the kitchen and he "ran him off". -Resident #18 got into the trash a lot. -Management was aware of Resident #18 eating out of the trash. -Typically there were only two bags of trash after every meal but today there was 5.</p> <p>Interview on 9/28/17 at 12:11 pm with Facility Operation Manager revealed: -The trash was emptied after every meal. -The trash cans could not be taken out of the dining room but he would "remove the bag in a little bit".</p> <p>Telephone interview on 10/02/17 at 9:42 am with Resident #18's Mental Health Provider revealed: -She felt this was a "personality quirk" and could not be controlled with medications. -There was no behavior plan just removing the trash quickly after each meal. -She was aware of a few times this had happened but not the recent occurrences since 9/27/17. -A behavioral plan will be addressed on her next visit in two weeks. -She considered this detrimental to Resident #18 because of the risk of contracting Hepatitis B or C from a known resident at the facility that had Hepatitis C.</p> <p>Interview with the Facility's Operations Manager on 10/2/17 at 2:07pm revealed: -Resident #18's issue with eating out of the trash</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 80</p> <p>would be more of a psychological problem and it would be reported to the Mental Health Provider as opposed to the Primary Care Provider.</p> <p>-Resident #18 was "hard to engage, he gets agitated easily."</p> <p>"-We try to empty the trash right after meals."</p> <p>-Resident #18 had a session with his Mental Health Provider today.</p> <p>Telephone Interview on 10/02/17 at 9:50 am with the Medical Office Assistant from the Primary care provider's office revealed:</p> <p>-They were not aware of Resident #18 eating out of the trash.</p> <p>-They would expect to be told and would expect the staff to put Resident #18 on 15 minute checks.</p> <p>-If there were other residents with Hepatitis C in the facility, they would be concerned and would expect his to be reported.</p> <p>Interview on 10/02/17 at 2:07 pm with the Administrator revealed:</p> <p>-She was aware of Resident #18 refusing meals and eating out of the trash.</p> <p>-The staff tried to encourage Resident #18 to eat all meals and ask the staff for food if she was hungry.</p> <p>-The trash was to be removed when full.</p> <p>-Resident #18 was not put on 15 minute checks.</p> <p>-They would continue to try to reach the mental health provider, "It is hard to get hold of them".</p> <p>Interview on 10/02/17 at 2:07 pm with the Operations Manager revealed:</p> <p>-She was aware of Resident #18 refusing meals and eating out of the trash.</p> <p>-The staff tried to redirect him and offer snacks.</p> <p>-She had tried to call the mental health provider today but there was no answer or return call.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 81</p> <p>Interview on 10/02/17 at 12:05 pm with a Medication Aide (MA) revealed: -She had been at the facility for 4 years as a MA. -She primarily worked 1st shift. -She was aware of Resident #18 getting in the trash and had done it 4-6 times in the past 6 months that she knew of. -Resident #18 got into the trash after everyone ate. -She tried to encourage him to eat his meals and not the trash. -The trash in the dining room was emptied after every meal. -It was the kitchen staffs' responsibility to empty the trash immediately after every meal.</p> <p>Refer to observation inside the medication room on 9/26/17 at 11:55am.</p> <p>Refer to interview with the Owner on 10/2/17 at 5:55pm.</p> <p>Refer to observation on 10/2/17 at 6:00pm.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am.</p> <p>Refer to interview with a second PCA on 9/26/17 at 6:16am.</p> <p>Refer to interview with a third PCA on 10/2/17 at 1:21pm.</p> <p>Refer to interview with a MA on 9/28/17 at 10:28am and 10/2/17 at 12:41pm.</p> <p>Refer to interview with the Mental Health Treatment Team Nurse (MHTTN) on 9/29/17 at 9:50am.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 82</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm.</p> <p>Refer to interview with the Owner on 9/29/17 at 7:30pm and 10/2/17 at 5:15pm.</p> <p>C. Review of Resident #9's current FL2 dated 8/24/17 revealed diagnoses included schizophrenia, mental retardation, traumatic brain injury, a history of motor vehicle accident, and ongoing tobacco abuse.</p> <p>Review of Resident #9's care plan dated 1/19/17 revealed: -He was independent with toileting, ambulation, dressing, and transfer. -He needed supervision with eating, bathing, and grooming.</p> <p>1. Observation on 9/25/17 at 9:55am revealed: -The activity room on the 100 hall smelled like fresh cigarette smoke. -There was a resident in the activity room playing the piano.</p> <p>Random interview with a resident on 9/25/17 at 9:55am revealed: -Some residents smoked cigarettes inside the activity room sometimes. -The resident did not know the names of residents who smoked cigarettes inside the activity room.</p> <p>Interview with the Resident Care Coordinator (RCC) on 9/28/17 at 4:46pm revealed Resident #9 went into other residents' rooms at night looking for either coffee or cigarettes.</p> <p>Interview with Resident #9's mental health</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 83</p> <p>provider Registered Nurse at 11:00am on 9/29/17 revealed Resident #9 had smoked in the facility before, but not recently.</p> <p>Interview at 9:50am on 10/2/17 with staff (Medical Office Assistants for both Primary care providers and one primary care provider) from Resident #9's primary care provider's office revealed: -The facility did not let the primary care provider know Resident #9 was smoking in the facility. -The primary care provider would expect to be told about such behaviors and would put the resident on 15 minute checks.</p> <p>Interview with Resident #9 on 10/2/17 at 1:00pm revealed: -He had lived at the facility about 6 or 7 months and liked it here. -He hasn't had any problems since living at the facility. -Staff "do not check on me." -Staff keep the cigarettes and lighter, "we get a cigarette every 2 hours." -"I don't borrow cigarettes." -"My roommate doesn't have a lighter either."</p> <p>Interview with the Operations Manager (OM) on 10/2/17 at 1:25pm revealed: -Residents observed, not just suspected, of smoking in the building would trigger 15 minute checks. -There were two residents in the facility on oxygen and both have private rooms. -Resident #9 doesn't go into those rooms.</p> <p>Interview with a Personal Care Aide (PCA) on 10/2/17 at 11:05am revealed: -Four residents were identified as smoking in the facility including Resident #9. -If a resident was caught smoking in their room,</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 84</p> <p>they are placed on smoking restrictions.</p> <ul style="list-style-type: none"> -Residents on smoking restrictions get a cigarette every 2 hours, but they do keep their lighters. -Resident #9 smokes in the facility daily. -"We ask him not to smoke in his room, but he steals cigarettes from other residents and smokes them in his room." -"We walk the halls and check on him (Resident #9) every 30 minutes and report to the supervisor." -"I've seen evidence of him smoking in his room, but never actually caught him smoking." -The evidence would be cigarette butts and the smell of smoke. -"(Named Resident #9) is really not a problem except for wandering at night and smoking." -"No residents have complained about other residents to me, if they did, I would pass it on to the supervisor." <p>Interview with a second PCA on 10/2/17 at 12:25pm revealed:</p> <ul style="list-style-type: none"> -The facility has a problem with 4 to 5 residents smoking in the building, sometimes on a daily basis. -Resident #9 was identified as 1 of the 4 or 5 residents who smoke in the building. -"They are put on smoking restrictions and if we catch another resident giving them cigarettes, they are put on smoking restrictions too." -Residents are put on 15 minute checks for things like, trying to leave the facility, smoking in the building, fighting, arguing, and going into other resident's rooms. -Residents stay on the 15 minute checks for 3 days, and "Resident #9 is on there a lot." <p>Review of Resident #9's record of 15 minute checks revealed:</p> <ul style="list-style-type: none"> -Only two sets of notes for 15 minute checks, 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 85</p> <p>each lasting 3 days.</p> <p>-One set of notes completed 8/9/17 through 8/11/17 for fighting with another resident.</p> <p>-Another set of notes completed for 8/24/17 through 8/27/17 for "back from hospital." (Community acquired pneumonia.)</p> <p>Interview with the facility Administrator on 10/2/17 at 12:55pm revealed:</p> <p>-We meet with his mental health provider every week.</p> <p>-Staff have to constantly redirect him (Resident #9.)</p> <p>-Resident #9 was on permanent smoking restriction.</p> <p>-"If you get caught smoking in the building you will be on smoking restrictions.</p> <p>-He can't have a lighter or cigarettes, "we keep them in the med room."</p> <p>Review of mental health provider notes for Resident #9 revealed:</p> <p>-6/22/17: Recent complaints about him going into other residents rooms, evidence of smoking inside facility. Facility noted, "discuss facility rules/regulations."</p> <p>-6/15/17: Again report of going into others rooms and smoking in facility, fairly easy to redirect most of the time. Facility noted, continue to educate/encourage on appropriate behaviors. (Named mental health provider) will educate on following facility rules/regulations.</p> <p>-9/6/17: Still reports of going into peoples room, recently caught smoking in room. Mental health noted, "will discuss appropriate behaviors, continue to monitor."</p> <p>-9/14/17: Smoking inside facility, reports of bothering people at night by opening their door, may have to explore other placement options. Mental health noted, "encourage compliance with</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 86</p> <p>facility rules."</p> <p>-9/22/17: Going into other residents' rooms, smoking in his room. Mental health noted, "(Named mental health provider) will monitor and encourage appropriate behaviors."</p> <p>Review of the facilities smoking policy revealed:</p> <p>-If a resident is caught smoking inside the building, immediately all smoking materials are taken from the resident.</p> <p>-The first time you are caught smoking inside the building, you will not be able to keep any smoking materials for 7 days, you will only be able to smoke with staff supervision. In addition to this, you will be charged a fine of 3.00 dollars to be deducted from your monthly payout, which will be donated to the local fire department.</p> <p>-The second time you are caught smoking inside the building, you will not be able to keep any smoking materials for 14 days, you will only be able to smoke with staff supervision. In addition to this, you will be charged a fine of 6.00 dollars to be deducted from your monthly payout, which will be donated to the local fire department.</p> <p>-The third time you are caught smoking inside the building, you will not be able to keep any smoking materials for 30 days, you will only be able to smoke with staff supervision. In addition to this, you will be charged a fine of 12.00 dollars to be deducted from your monthly payout, which will be donated to the local fire department.</p> <p>-Along with the restrictions listed above, you will not be allowed to have a coffee maker or microwave in your room for the duration of your restriction. These items will be immediately stored in the facility office until your restriction is over.</p> <p>-As well as smoking restriction and monetary fines, you may also be given a notice to leave the facility for smoking in the building.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 87</p> <p>-There is a signature for management and a date when existing resident was given a copy. -This smoking policy was revised on 12/18/14.</p> <p>2. Interview with a Medication Aide (MA) on 9/26/17 at 5:18am revealed: -She had gotten some complaints about Resident #9 going into other residents' rooms and stealing things. -The MA believed Resident #9's mental health provider had "followed up on this."</p> <p>Interview with the Resident Care Coordinator (RCC) on 9/28/17 at 4:46pm revealed: -Resident #9 was up sometimes a night and went into other residents' rooms. -She was aware of Resident #9 going into other residents' room only once or twice.</p> <p>Interview at 9:50am on 10/2/17 with staff (Medical Office Assistants for both Primary care providers and one primary care provider) from Resident #9's primary care provider's office revealed: -The facility did not let the primary care provider know Resident #9 was going into other residents' rooms uninvited. -The primary care provider would expect to be told about such behaviors and would put the resident on 15 minute checks.</p> <p>Interview with Resident #9's mental health provider Registered Nurse at 11:00am on 9/29/17 revealed: -Resident #9 had difficulty sleeping, so he sleeps during the day and stays up at night. -We encourage staff to try and keep him up during the day so he will sleep at night. -Resident #9 had gone in and out of other residents rooms, "he doesn't respect boundaries." -He had never been aggressive or violent.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 88</p> <ul style="list-style-type: none"> -We have been working with Resident #9 since April 2017. -We've tried to find things he likes to do, but "he isolates himself and was hard to engage." -Resident #9 had hit a plateau, "he's not better or worse." <p>Interview with Resident #9 on 10/2/17 at 1:00pm revealed:</p> <ul style="list-style-type: none"> -He had lived at the facility about 6 or 7 months and liked it here. -He hasn't had any problems since living at the facility. -Staff "do not check on me." -He has no problems sleeping, but he does get up late, around lunchtime. -He likes to visit other residents. -"I knock on the door and if they don't answer, I peek in." -"If they aren't in the room, I don't go in." <p>Interview with the facility Administrator on 10/2/17 at 12:55pm revealed:</p> <ul style="list-style-type: none"> -"We meet with Resident #9's mental health provider every week." -Mental health had plans and goals for Resident #9 and we continue with redirection. -Staff constantly redirect him. -"We thought he was doing better about going into other residents' rooms." -"He was usually looking for cigarettes or soda." -There haven't been any complaints from other residents about Resident #9 going into their rooms. -He sleeps most of the day. <p>Interview with the Operations Manager (OM) on 10/2/17 at 1:25pm revealed:</p> <ul style="list-style-type: none"> -Residents observed, not just suspected, of going into other residents' rooms uninvited would trigger 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 89</p> <p>15 minute checks.</p> <ul style="list-style-type: none"> -We can check the facility cameras to see if a resident goes into another residents' rooms. -There were two residents in the facility on oxygen and both have private rooms. -Resident #9 doesn't go into those rooms. <p>Interview with a PCA on 10/2/17 at 11:05am revealed:</p> <ul style="list-style-type: none"> -"We try to check on him (Resident #9) every 30 minutes and report to the supervisor." -"(Named Resident #9) is really not a problem except for wandering at night and smoking." -Resident #9 sleeps all day, and is up at night, we can't make him stay up." -"No residents have complained about other residents to me, if they did, I would pass it on to the supervisor." <p>Interview with a second PCA on 10/2/17 at 12:20pm revealed:</p> <ul style="list-style-type: none"> -Resident #9 goes in and out of other residents' rooms. -We monitor residents with 15 minute checks when they are caught going into other residents rooms. -The 15 minute checks last for 3 days. -We check on them every 15 minutes and document where we find the resident. -Residents are put on 15 minute checks for things like, trying to leave the facility, smoking in the building, fighting, arguing, and going into other resident's rooms. -Residents stay on the 15 minute checks for 3 days, and "Resident #9 is on there a lot." -If we find a resident going into another resident's room uninvited, we report it to the Supervisor. <p>Interview with a third Personal Care Aide (PCA) on 9/26/17 at 5:30am revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 90</p> <ul style="list-style-type: none"> -Resident #9 wandered into other residents' rooms frequently during meal times when everyone was in the dining room. -Resident #9 never took anything, he would just go in the rooms to look around. -When staff find Resident #9 in other residents' rooms they redirect him. <p>Interview with a fourth Personal Care Aide (PCA) on 10/2/17 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -Resident #9 "usually did his thing" meaning he wandered into other residents' rooms on 3rd shift. -The 3rd shift staff usually put a chair in the hallway to keep an eye on Resident #9. -Resident #9 usually slept during the day. -Staff tried to keep an eye on Resident #9 and keep him out of other residents' rooms. <p>Confidential interviews with a resident revealed:</p> <ul style="list-style-type: none"> -Resident #9 went in other residents' rooms all the time. -The resident had seen Resident #9 go in another resident's room on 9/26/17 when the other resident was in the medication line. -Resident #9 wandered into other residents' rooms at night and that made the resident uncomfortable and afraid for what Resident #9 was doing in residents' rooms when they were sleeping. -Residents had reported Resident #9 going in other residents' rooms and staff did not do anything about it. <p>Review of Resident #9's record of 15 minute checks revealed:</p> <ul style="list-style-type: none"> -Only two sets of notes for 15 minute checks, each lasting 3 days. -One set of notes completed 8/9/17 through 8/11/17 for fighting with another resident. -Another set of notes completed for 8/24/17 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 91</p> <p>through 8/27/17 for "back from hospital." (Community acquired pneumonia.)</p> <p>Review of mental health provider notes for Resident #9 revealed:</p> <p>-6/22/17: Recent complaints about him going into other residents rooms, evidence of smoking inside facility. Facility noted, "discuss facility rules/regulations."</p> <p>-6/15/17: Again report of going into others rooms and smoking in facility, fairly easy to redirect most of the time. Facility noted, "continue to educate/encourage on appropriate behaviors. (Named mental health provider) will educate on following facility rules/regulations."</p> <p>-6/29/17: Lots of complaints of him going into others rooms, upsetting other residents. Mental health noted, "will discuss issues with client."</p> <p>-Undated note: Increase in going into rooms and reports of theft, needs to use spit jar.</p> <p>-8/10/17: A lot of reports of him going into others rooms, caused altercation with another resident. Asking to go to another facility. (Named mental health provider) "will continue to provide treatment."</p> <p>-8/17/17: Upsetting others by going into rooms at night. Mental health noted, "will discuss with client."</p> <p>-9/6/17: Still reports of going into peoples room, recently caught smoking in room. Mental health noted, "will discuss appropriate behaviors, continue to monitor."</p> <p>-9/14/17: Smoking inside facility, reports of bothering people at night by opening their door, may have to explore other placement options. Mental health noted, "encourage compliance with facility rules."</p> <p>-9/22/17: Going into other residents' rooms, smoking in his room. Mental health noted, (Named mental health provider) "will monitor and</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 92</p> <p>encourage appropriate behaviors."</p> <p>Refer to observation inside the medication room on 9/26/17 at 11:55am.</p> <p>Refer to interview with the Owner on 10/2/17 at 5:55pm.</p> <p>Refer to observation on 10/2/17 at 6:00pm.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am.</p> <p>Refer to interview with a second PCA on 9/26/17 at 6:16am.</p> <p>Refer to interview with a third PCA on 10/2/17 at 1:21pm.</p> <p>Refer to interview with a MA on 9/28/17 at 10:28am and 10/2/17 at 12:41pm.</p> <p>Refer to interview with the Mental Health Treatment Team Nurse (MHTTN) on 9/29/17 at 9:50am.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm.</p> <p>Refer to interview with the Owner on 9/29/17 at 7:30pm and 10/2/17 at 5:15pm.</p> <p>D. Review of Resident #6's current FL-2 dated 6/26/17 revealed diagnoses included Schizoaffective Disorder; Bipolar Type.</p> <p>Review of Resident #6 current care plan dated 10/19/16 revealed: -Staff documented Resident #6 was admitted to</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 93</p> <p>the facility in October 2015 and came from a group home.</p> <ul style="list-style-type: none"> -Resident #6 had a supportive guardian and was receiving mental health services. -When Resident #6 was having a bad day he was loud, responded to "internal stimuli" by yelling, was difficult to redirect and focused on leaving the facility. -If Resident #6 was difficult to redirect, as needed medication (PRN) should be used and contact the mobile crisis team if the PRN was not effective. <p>Confidential interviews with a resident revealed:</p> <ul style="list-style-type: none"> -A resident had been hit in the leg by a chair that Resident #6 threw about a week and half ago (9/13/17) in the common area near medication room. -Staff knew because staff was there and saw the incident where Resident #6 was throwing chairs because he was upset. -Resident #6 was prone to "violent temper tantrums." -The resident "wished (surveyors) could come more often because some of the residents never behaved this well." -There was usually a lot of verbal abuse, fighting and yelling in the medication lines and food lines. -Staff had spoken to problem residents and told them to behave because "this was not their norm." <p>Confidential interviews with a resident revealed:</p> <ul style="list-style-type: none"> -There were residents in the facility that made the resident feel uncomfortable. -Resident #6 was one of those residents because he would persistently get in the residents personal space. -Resident #6 would keep flirting with and trying to talk to the resident after the resident told Resident #6 to stop trying to talk to her. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 94</p> <ul style="list-style-type: none"> -The resident had seen Resident #6 throw chairs and break them outside the facility several times in the last couple of months. -They really needed to supervise residents outside smoking and during meals because there was a lot of yelling between residents while they were eating. -Staff were not able to supervise residents in the dining room because they were constantly passing out trays. -Residents reported concerns to staff, but nothing was done about it. <p>Confidential interview with a staff revealed:</p> <ul style="list-style-type: none"> -There were "threatening" residents at the facility and Resident #6 was one of them. -Resident #6 had thrown a couch at the exit doors, threw chairs at a resident who was no longer at the facility and smoked cigarettes in the building. -There were no consequences for their behaviors, they actually got what they wanted when they acted out. -If they wanted a cigarette, the residents knew to start yelling, banging on doors and throwing stuff around because then staff would give them a cigarette to calm them down. <p>Observations on 9/25/17 from 10:15am until 11:15 am revealed:</p> <ul style="list-style-type: none"> -There were at minimum 14 residents outside of the building and there were no staff observed. -The 14 residents were walking around the building, smoking cigarettes, sitting in smoking areas, walking up to the road and back to the facility and sweeping up cigarette butts. -Resident #6 was among the 14 residents outside the facility. <p>Observation on 9/26/17 at 3:57pm revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 95</p> <ul style="list-style-type: none"> -Resident #6 was banging loudly on the administrative office door for several minutes. -Resident #6 was yelling aggressively for someone to answer the door because he wanted a cigarette. -No one answered the door and no staff responded to Resident #6 behavior. -There was no staff near the 100 hall/administrative office door. <p>Interview with Resident #6 on 9/26/17 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -He was angry and frustrated because he wanted a cigarette. -The Operations Manager (OM) said she would give him a cigarette and did not. <p>Observation on 9/28/17 at 3:40pm revealed:</p> <ul style="list-style-type: none"> -Staff I knocked on the Assistant Operations Manager's (AOM) office door. -Staff I informed the AOM Resident #6 was "raising hell" down on the 300/400 hall because he was getting a roommate. -The AOM informed Staff I he would be down to talk to Resident #6 and commented that he handled resident disputes. -The AOM declined further interview and left to talk to Resident #6. <p>Interview with Resident #6 on 9/29/17 at 6:20pm revealed the resident declined to speak with surveyor.</p> <p>Telephone interview with Resident #6's guardian on 10/2/17 at 10:54am revealed:</p> <ul style="list-style-type: none"> -She was not able to visit the facility often. -Resident #6 had a tendency toward violent outbursts. -Nothing would really happen when the resident had an outburst. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 96</p> <p>-Facility staff might take him to the hospital and let him lay up for a while.</p> <p>-Resident #6 was supposed to have a care plan where staff helped him.</p> <p>Review of Charting notes for Resident #6 dated 5/1/17 through 9/6/17 revealed:</p> <p>-On 5/1/17 at 10:19am, staff documented Resident #6 walked off from the facility at 7:00am, was not permitted to go to the day program and started cussing at staff, beating doors and throwing chairs across the day room; a PRN medication was given and the mobile crisis team was called.</p> <p>-On 5/1/17 at 9:00pm, the OM documented Resident #6 had been agitated most of the day with nausea, vomiting and an elevated blood pressure; the Primary Care Provider (PCP) was contacted and medications were administered.</p> <p>-On 5/18/17 at 11:37am, the OM documented Resident #6 left the grounds at the day program, returned to the facility "extremely agitated, throwing chairs, going after another resident in an aggressive manner (redirected before contact was made), threatening to kill staff and animals in the neighborhood and threatening to leave the facility; PRN medications were not effective.</p> <p>-On 5/18/17 at 12:21pm, the OM documented Resident #6 was "very aggressive," threatening staff and smoking in the facility; law enforcement and the mobile crisis team were contacted.</p> <p>-On 6/4/17 at 5:33am, the OM documented Resident #6 had been up most of the night and had to be redirected from another resident's room at 5:00am.</p> <p>-On 6/12/17 at 3:40pm, staff documented Resident #6 was walking away from the facility because he wanted to leave "almost daily," the mental health treatment team was contacted and came and talked to the resident.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 97</p> <p>-On 6/16/17 at 12:19pm, the OM documented Resident #6 was verbally aggressive with increased delusions, responding to internal stimuli with yelling, banging on doors/walls and threatening to harm others; mobile crisis and the residents guardian were contacted and Resident #6 was Involuntarily Committed (IVC'd).</p> <p>-On 6/26/17 at 2:49pm, the OM documented Resident #6 was returning to the facility from the hospital.</p> <p>-On 8/17/17 at 12:22pm, the OM documented Resident #6 had increased agitation, was cussing, yelling and threatening others and was attempting to beat windows and jerk doors off hinges; mobile crisis and the resident's guardian were contacted, a PRN was given and the resident was placed on 15 minute checks.</p> <p>-On 8/18/17 at 12:22pm, the OM documented that management had met with Resident #6's Mental Health Provider (MHP) on 8/17/17 to discuss recent behaviors.</p> <p>-On 9/1/17 at 9:06am, staff documented Resident #6 had increasing agitation, was hearing voices telling him to do things, reported needing help before he hurt somebody, was screaming and yelling threats to harm others, threw chairs, beat windows and refused PRN; mobile crisis contacted and the resident was placed on 15 minute checks.</p> <p>-On 9/5/17 at 5:04am, the OM documented Resident #6 was IVC'd on 9/1/17 and the guardian was contacted.</p> <p>-On 9/6/17 at 1:46pm, staff documented Resident #6 returned to the facility from the hospital.</p> <p>Review of "15 minute Check" sheets for Resident #6 revealed:</p> <p>-There was documentation of 15 minute checks for 5/1/17 at 7:00am through 5/2/17 at 11:00pm.</p> <p>-Staff documented behaviors of walking off from</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 98</p> <p>facility, throwing chairs in the day room, beating on doors and yelling/cussing from 7:00am on 5/1/17 through 12:15pm on 5/1/17.</p> <p>-There was no documentation of any 15 minute checks on 5/18/17 or 6/12/17.</p> <p>-There was documentation of 15 minute checks for 6/26/17 at 8:00pm through 6/27/17 at 2:00pm, 6/27/17 at 3:00pm through 6/28/17 at 3:00pm and 6/28/17 at 11:00pm through 6/29/17 at 3:00pm.</p> <p>-There were no 15 minute checks documented for 6/27/17 from 2:00pm until 3:00pm and 6/28/17 from 6/28/17 at 3:00pm until 6/28/17 at 11:00pm.</p> <p>-There was no documentation of 15 minute checks for 8/17/17.</p> <p>-There was documentation of 15 minute checks for 9/1/17 at 7:00am through 9/1/17 at 3:00pm.</p> <p>-There was documentation of 15 minute checks for 9/6/17 at 3:00pm through 9/9/17 at 3:00pm.</p> <p>Review of "Accident/Injury Reports" dated 5/1/17 through 9/25/17 for Resident #6 revealed:</p> <p>-There was a report dated 5/18/17 with no time documenting law enforcement and the mobile crisis team were contacted for Resident #6 being agitated, aggressive toward another resident with no physical contact, making threats and staff were unable to redirect.</p> <p>-The report was signed by the OM and dated 9/29/17.</p> <p>-There was a report dated 6/16/17 with no time documenting Resident #6 was IVC'd for being verbally aggressive with increased delusions and was responding to internal stimuli.</p> <p>-The report was signed by the OM and dated 6/16/17.</p> <p>-There was a report dated 9/1/17 documenting Resident #6 was IVC'd for threatening to harm others, throwing chairs and yelling and screaming.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 99</p> <p>Review of untitled weekly meeting forms dated 6/22/17 through 9/22/17 for Resident #6 revealed:</p> <ul style="list-style-type: none"> -On 7/26/17, the OM documented Resident #6's behaviors had improved since hospitalization. -On 8/4/17, the OM documented Resident #6 had an increased response to internal stimuli and was easy to redirect; the mental health treatment team (MHTT) member documented continued work with Resident #6 to educate and encourage appropriate behaviors. -On 8/10/17, the OM documented Resident #6 had increased agitation and verbal outbursts and the MHTT member documented the treatment team would continue treatment. -On 8/17/17, the OM documented Resident #6 had increased aggression, verbal outbursts, physical aggression and threats to harm others; there was no documentation from the MHTT member. -On 9/6/17, the OM documented Resident #6 was returning to the facility and the MHTT member documented the treatment team would monitor for symptoms. -On 9/14/17, the OM documented Resident #6 was upset, agitated, verbally aggressive, manipulative and attempted to leave group on outings; and the MHTT member documented the treatment team would monitor behaviors and encourage coping skills when the resident did not get his way. -There was no documentation of planned interventions for facility staff to manage Resident #6's aggressive and threatening behaviors on any of the weekly meeting forms. <p>Review of charting notes, Accident/Injury Reports and 15 minute check sheets revealed:</p> <ul style="list-style-type: none"> -There were no charting notes entries after 9/6/17. -There were no Accident/Injury reports dated after 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 100</p> <p>9/1/17. -There were no 15 minute checks after 9/9/17.</p> <p>Review of Resident #6's "Person Centered Plan" including the "Crisis Prevention and Intervention Plan" revealed: -The document was dated 8/14/17 and was 12 pages long. -There was no clear instructions or interventions for facility staff in the event Resident #6 demonstrated crisis behaviors such as aggression and threats of harm.</p> <p>Based on observations, interviews and record reviews, Resident #6 had a known history and pattern of escalating violent and potentially injurious behavior of throwing furniture and threatening others leading to frequent hospitalizations for IVC. There was a report of staff witnessing Resident #6 injuring a resident on or about 9/13/17 and documented escalation in agitation and verbal aggression on the 9/14/17 weekly meeting form with no documentation of 15 minute checks for 9/13/17 and 9/14/17. Resident #6 was observed banging on the administrative office door and yelling aggressively on 9/26/17 and outside the facility on 9/25/17 with no staff presence or response. There was no documented plan, strategies or intervention to monitor and supervise Resident #6 and protect other residents.</p> <p>Interview with a Personal Care Aide (PCA) on 10/2/17 at 1:21pm revealed: -Resident #6 would usually scream and holler when he did not get his way. -Resident #6 would usually take a PRN, sit in a chair in the common area, sleep and wake up fine. -She had only seen Resident #6 throw chairs</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 101</p> <p>once out in the parking lot, once out on the "porch" and once in the day room.</p> <ul style="list-style-type: none"> -There were no residents outside when Resident #6 was throwing chairs. -Staff removed the residents from the day room and no one was hit with anything. -Whenever Resident #6 did things like throwing chairs, staff called the mobile crisis team, gave a PRN and put the resident on 15 minute checks. <p>Interview with a Medication Aide (MA) on 10/2/17 at 12:41pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 was throwing chairs in the common area near the medication room on 8/17/17. -Resident #6 was throwing the chairs in general and was not throwing the chairs at anyone specifically. -Resident #6 was making generalized threats and did not threaten anyone specifically. -There should have been 15 minute checks because that was an incident on 8/17/17. -The PCAs were responsible for initiating the 15 minute check sheet. -On 9/1/17, Resident #6 refused his morning medications and a PRN. -She was not aware of Resident #6 harming another resident while throwing chairs. -If a staff witnessed the incident they should have reported it because the staff could get in trouble for not reporting the incident and there were cameras in the building. <p>Review of Resident #6's September 2017 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Clonazepam 1 mg every eight hours as needed for anxiety. (Clonazepam is a benzodiazepine used to treat anxiety.) -There was documentation doses were administered on 9/6/17 at 11:03pm, 9/18/17 at 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 102</p> <p>4:19pm, 9/19/17 at 5:55pm, 9/22/17 at 10:58pm, 9/25/17 at 5:26pm and 9/26/17 at 4:00pm.</p> <ul style="list-style-type: none"> -There was documentation that all doses administered were effective. -There was an entry for Haloperidol 5mg every two hours as needed for agitation. (Haloperidol is an antipsychotic used to treat Schizophrenia.) -There was documentation a dose was administered on 9/19/17 at 10:21pm and was effective. <p>Interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm revealed:</p> <ul style="list-style-type: none"> -She was not aware of any other resident being injured by Resident #6 throwing furniture. -Resident #6 usually got agitated and the MA would give him a PRN and take the resident outside. -If Resident #6 was "really agitated" then the staff would stay with the resident outside. -If the PRN did not work, the MA would call Resident #6's MHP. <p>Telephone interview with Resident #6's Primary Care Provider (PCP) on 9/28/17 revealed:</p> <ul style="list-style-type: none"> -Resident #6 had an issue with elevated blood pressure in the spring of 2017 which seemed to be under control now. -Resident #6 had problems with behavior. -Resident #6 was frequently agitated and violent at times. -Resident #6 was followed by a MHP. <p>Interview with the Mental Health Treatment Team Nurse (MHTTN) on 9/29/17 at 10:15am revealed:</p> <ul style="list-style-type: none"> -Resident #6 "almost liked to push the limit with aggressive behaviors," and used his size to intimidate people to get what he wanted. -The treatment team was working with Resident #6 on understanding boundaries. 	D 270		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 103</p> <ul style="list-style-type: none"> -The treatment team expected all staff to be consistent and use the same plan of care. -Resident #6 knew if he could get something he wanted from one staff, but not another, he would get what he wanted from that one staff. -The facility staff was not currently consistent with setting boundaries for Resident #6. -She could not say if facility staff could effectively manage Resident #6's behaviors. -She was not aware of any other residents being injured by Resident #6 throwing furniture at the facility. -She was not aware of any written plan of interventions for the facility to manage Resident #6's behaviors. -In instances where Resident #6 was being aggressive, threatening or violent, she expected facility staff to administer a PRN and call the crisis team. <p>Telephone interview with Resident #6's MHP on 10/2/17 at 11:02am revealed:</p> <ul style="list-style-type: none"> -He had seen Resident #6 at the facility since July 2017 and previously in 2015. -Staff informed him of Resident #6's aggressive behavior and agitation. -He was not aware of Resident #6 injuring any other residents. -Resident #6 was usually awake a good part of night and upset in the afternoons related to not getting cigarettes. -Interventions to manage resident #6's behaviors were documented on the crisis plan. -He could not recall any specific interventions but knew the treatment team and the facility met weekly to discuss interventions. <p>Telephone interview with the Supervising Nurse Practitioner at Resident #6's PCP's office on 10/2/17 at 9:50am revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 104</p> <ul style="list-style-type: none"> -They had not gotten any calls from the facility about any residents being injured by Resident #6 throwing furniture. -They were not aware of any injuries to other residents. <p>Interview with the Operations Manager (OM) on 10/2/17 at 2:39pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 responded to internal stimuli meaning voices in his head. -Other people may think the resident was talking to them in an aggressive tone, but the resident was really responding to voices in his head. -Resident #6 was not inside the facility when he was throwing chairs on 5/1/17 and no one was hurt. -She did not document other resident names in charting notes/incident reports and did not remember which resident, Resident #6 was "going after" on 5/18/17. -Sometimes Resident #6 was not threatening people directly, but was talking to the voices in his head and making generalized threats. -No one had reported any resident being injured from a chair being thrown by Resident #6. <p>Refer to observation inside the medication room on 9/26/17 at 11:55am.</p> <p>Refer to interview with the Owner on 10/2/17 at 5:55pm.</p> <p>Refer to observation on 10/2/17 at 6:00pm.</p> <p>Refer to interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am.</p> <p>Refer to interview with a second PCA on 9/26/17 at 6:16am.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 105</p> <p>Refer to interview with a third PCA on 10/2/17 at 1:21pm.</p> <p>Refer to interview with a MA on 9/28/17 at 10:28am and 10/2/17 at 12:41pm.</p> <p>Refer to interview with the Mental Health Treatment Team Nurse (MHTTN) on 9/29/17 at 9:50am.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm.</p> <p>Refer to interview with the Owner on 9/29/17 at 7:30pm and 10/2/17 at 5:15pm.</p> <hr/> <p>Observation inside the medication room on 9/26/17 at 11:55am revealed: -There was a Medication Aide (MA) inside the medication room with the doors closed. -There was knocking on the door for a few minutes. -The MA opened the door for another staff and said, "I thought you were a resident."</p> <p>Interview with the Owner on 10/2/17 at 5:55pm revealed in response to Resident #5 knocking on the Administrator's office window, "There's someone knocking, is that a supervision issue?"</p> <p>Observation on 10/2/17 at 6:00pm revealed Resident #6, Resident #16 and several other residents were outside of the facility near the 100 and 200 hall entrances and there was no staff present.</p> <p>Interview with a Personal Care Aide (PCA) on 9/26/17 at 5:30am revealed: -She was not aware of any residents in the facility</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 106</p> <p>with behavior concerns.</p> <ul style="list-style-type: none"> -There were some residents who argued with other residents randomly over "a cup, a quarter or who sat where in the dining room." -Staff were able to redirect residents when they had arguments. -She was not aware of any resident feeling uncomfortable, bullied or threatened by another resident. -Facility staff had been trained on how to recognize behavior changes. -There were two residents on 15 minute checks all the time; one resident for her behaviors and a second resident for a fluid restriction. <p>Interview with a second PCA on 9/26/17 at 6:16am revealed she was not aware of any residents with behavior issues such as wandering, agitation and aggression.</p> <p>Interview with a third PCA on 10/2/17 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -Residents were put on 15 minute checks for behaviors, walking off or anything out of the ordinary. -The 15 minute check sheets were kept in the staff break room and the PCA was responsible for initiating the sheet. -The PCAs documented where the resident was and what they were doing every 15 minutes. -The 15 minute check sheet was given to the Supervisor at the end of each shift for review and then the Supervisor signed the sheet. <p>Interview with a MA on 9/28/17 at 10:28am and 10/2/17 at 12:41pm revealed:</p> <ul style="list-style-type: none"> -The 15 minute checks meant that the PCAs checked where a resident was and what they were doing every 15 minutes and documented it on a 15 minute check sheet. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 107</p> <ul style="list-style-type: none"> -The PCAs did 15 minute checks on residents for 72 hours after an incident occurred. -The 15 minute checks were not assigned to a particular PCA each shift. -All staff were made aware of 15 minute checks and the PCAs worked it out amongst themselves who was going to do the 15 minute checks. -All of the residents were checked every two hours. -The residents did not usually fight or argue in the medication and food lines. -Staff checked off a resident census at each meal and if a resident was not in the dining room for a meal, the PCA went to find the resident. -If a resident was on 15 minute checks, staff were responsible for going and checking on that resident. -There were typically three to four PCAs in the dining room for each meal. <p>Interview with the Mental Health Treatment Team Nurse (MHTTN) on 9/29/17 at 9:50am revealed:</p> <ul style="list-style-type: none"> -The treatment team had weekly meetings with the facility to discuss any recent changes in symptoms or behavior. -The OM and a crisis team member attended the meeting. -The treatment team went back to their offices and discussed possible interventions and returned to the facility to carry out any planned interventions. -When the treatment team received a crisis call they tried to find out where the resident was, if there were suicidal thoughts they recommended to staff to monitor resident until the crisis team arrived at the facility. -When the treatment team responded to residents in crisis the team member did teaching with the staff and the resident to circumvent behaviors. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 270	<p>Continued From page 108</p> <p>-The team member usually interacted with PCAs and MAs because they were usually directly involved.</p> <p>Interview with the Resident Care Coordinator (RCC) on 9/29/17 at 6:23pm revealed:</p> <p>-The facility staff did every two hour checks on all residents and every 15 minute checks for any behaviors or residents coming back from the hospital.</p> <p>-She did not have a comment for staff being able to perform 15 minute checks, supervise other resident behaviors, assist in the dining room at each meal, clean laundry and provide bathing and incontinence care for residents.</p> <p>Interview with the Owner on 9/29/17 at 7:30pm and 10/2/17 at 5:15pm revealed:</p> <p>-Residents' behaviors were symptoms of the mental illness.</p> <p>-Staff always called the mobile crisis when residents had behaviors and communicated with the resident's MHP immediately.</p> <p>-It was an exceptional situation in the facility that 15 minute checks were in place for a resident.</p> <p>-Residents were supervised based on their identified needs which were documented in the residents care plan.</p> <p>-Each resident had a crisis plan that was available for all staff to refer to.</p> <p>Refer to Tag 188 10A NCAC 13F .0604(e)(1) Personal Care and Other Staff (Type B Violation)</p> <p>Refer to Tag 189 10A NCAC 13F .0604(e)(2) Personal Care and Other Staff (Type B Violation)</p> <hr/> <p>The facility failed to provide supervision to 4 of 9 sampled residents (#6, #9, #16, and #18). This</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 109</p> <p>failure exposed Resident #16 to ingestion of toxic substances for the purpose of becoming intoxicated, Resident #18 to eating discarded food from the trash, exposing him to risk of infection with hepatitis C, Resident #9 to fighting, smoking inside the facility, and wandering into other residents rooms in order to steal, and Resident #6 who had a history of violent outbursts with threats to staff and other residents resulting in hospitalizations for involuntary commitment, with symptoms of escalating aggression since mid September 2017 and no evidence of monitoring for safety. Therefore this failure to supervise exposed residents to the risk of serious physical harm and neglect, and constitutes a Type A2 Violation.</p> <hr/> <p>Review of the Plan of Protection provided by the facility on 9/29/17 revealed: -Staff will provide supervision of residents in accordance with each residents assessed needs and current symptoms. -Behaviors which elevate to a crisis level will be referred to the appropriate mental health crisis provider with staff actively monitoring the situation until crisis services arrive. -All incidents will be reviewed regularly to ensure residents' needs are being met. -Regular communication for significant resident behaviors will be communicated to residents' mental health providers.</p> <p>DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2017.</p>	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 276	<p>Continued From page 110</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 1 of 6 sampled residents with physician's orders for wound care and dressing changes (Resident #15).</p> <p>The findings are:</p> <p>Review of Resident #15's current FL2 dated 6/15/17 revealed diagnoses included dementia secondary to Parkinson's, chronic obstructive pulmonary disease (COPD), osteoarthritis and hypothyroidism.</p> <p>Review of a physician's order dated 9/19/17 from the primary care provider revealed an order to wash left foot two times a day with soap and water, apply polysporin two times a day, apply sterile dressing twice daily and as needed if soiled, for 7 days and provider would recheck on Thursday's visit (no date).</p> <p>Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings observation on 9/26/17 at 7:33 am of room #210.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 276	<p>Continued From page 111</p> <p>Observation on 9/26/17 at 7:33 am of Resident #15 revealed: -She was walking around in her room in her room with no socks, shoes or dressings. -The bottom of her feet were black and her left foot was bleeding. -There was a 10 mm sized dark area on the ball of her foot between the second and third toe with blood around it.</p> <p>Observations on 9/27/17 at 1:00 pm, 5:00 pm and 6:00 pm of Resident #15 revealed she was without a dressing to left foot.</p> <p>Observation on 9/28/17 at 9:00 am of Resident #15 revealed she was laying on her bed without shoes and both feet were black with a scant amount of blood to the wound area on left foot. There was no dressing on her left foot.</p> <p>Interview on 9/26/17 at 7:33 am with Resident #15 revealed: -She had a procedure on the bottom of her left foot last week. -She was to get wound care 2 times a day with ointment and a dressing. -She got the ointment but no dressing. -The Medication Aides (MA) were responsible for the wound care on her feet. -She was concerned with how dirty the floors were and reported it to the housekeeping staff and they mopped the room.</p> <p>Interview on 9/26/17 at 8:29 am with a MA revealed: -She was a MA since 2008 and worked 1st shift primarily. -Resident #15 received wound care to her left leg 2 times a week by Home Health and as need by</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	<p>Continued From page 112</p> <p>the MAs there.</p> <p>-She was not aware of the wound care to the bottom of her left foot and thought she was just to apply polysporin 2 times a day.</p> <p>-She applied polysporin on 9/23/17 and 9/24/17 at 8:00 am to the resident's left foot wound.</p> <p>Interview on 9/26/17 at 12:30 pm, 1:30 pm and 9/27/17 at 11:30 am with the Resident Care Coordinator (RCC) revealed:</p> <p>-She was the RCC for 6 years.</p> <p>-The care of the wound to Resident #15's left leg was on the Medication Administration Record (MAR) and was "being done as ordered".</p> <p>-She was not aware of the order for the wound care and the dressing changes for the left foot.</p> <p>-She was not sure how the order was overlooked.</p> <p>-She was not aware of the treatment order for Resident #15's left foot.</p> <p>-All new orders were faxed to the pharmacy once received.</p> <p>-The pharmacy was responsible for entering all new orders into the eMAR and the entries were to be verified by the MAs before medications could be given.</p> <p>-She was not aware of anyone who would check all of the eMARs at the end of the month for accuracy, missed or refused medications or treatments.</p> <p>-She was ultimately responsible for making sure all orders were faxed to the pharmacy but MAs could fax any new orders as well.</p> <p>-Any clarifications should be directed to the provider who wrote the order.</p> <p>-Any medication or treatment errors were reported to her and to the Operations Manager.</p> <p>Interview on 9/28/17 at 2:18 pm with the Administrator revealed:</p> <p>-She was aware of the wound care for Resident</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	<p>Continued From page 113</p> <p>#15. -She was not aware the dressings had not been put on. -She would check with the RCC about the wound care. -She expected the MAs to follow the provider's orders. -All concerns should be followed up with the provider.</p> <p>Telephone interview on 9/28/17 at 3:00 pm with Resident #15's Primary Care Provider revealed: -He was not aware the dressing changes were not implemented according to his order for Resident #15's left foot. -He did not receive notification about the condition of Resident #15's left foot. -He expected the staff to follow his order as it was written. -He saw Resident #15 on 9/19/17, removed a planter's wart and ordered for the wound care to be done. -He "would not have removed the wart" if the wound care was not going to be done as ordered. -He considered the lack of wound care detrimental to Resident #15 because the risk of infection to the left foot and her other wound with healing issues on her left leg.</p> <hr/> <p>The facility failed to implement physician order's for wound care and dressing changes, twice daily for 7 days for a wound on the bottom of Resident #15's foot. This resulted in the wound on the bottom of Resident #15's left foot to become soiled and bleed, which caused an increased risk for infection. This was detrimental to the health and safety of Resident #15 and constitutes a Type B Violation.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 114 Review of the Plan of Protection provided by the facility on 9/29/17 revealed: -Written procedures, treatments, and /or orders from physicians will be implemented in a timely manner. -Orders will be placed in an order log and on MAR for documentation. -Facility order log will be reviewed by the Operations Manager no less than 3 times per week. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2017.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the kitchen and dining room were kept clean, orderly and free from contamination as evidenced by heavy dirt, dust and food particles on the floors in the dining room and pantry, dead flies on the window sills in the dining room and drip marks, scuff marks and finger print on the doors to the kitchen and dining room. The findings are:	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 282	<p>Continued From page 115</p> <p>Observations on 9/25/17 at 4:30pm, 9/26/17 at 7:50am and 9/28/17 at 12:09pm revealed:</p> <ul style="list-style-type: none"> -There was heavy dirt and dust accumulations on the floor under and in front of the baseboard heater, the floor corners and the floor around the entrances to both dining rooms. -There were numerous scuff marks at the bottom of the door to the kitchen from the dining room. -There were finger prints and dirt build up covering an area of approximately three inches by twelve inches around and above the door knob on the door to the kitchen from the dining room. -There were yellow, orange and brown drip marks on the walls in the main dining room and the marks were especially heavy on the walls behind the serving cart and around the serving window to the kitchen. -There were heavy scuff marks from the bottom to near the height of the door knob on the exit door to the outside from the dining room. -There were yellow, orange and brown drip marks on the walls around the hand washing sink in the kitchen and behind the pantry door. -There was heavy dirt, dust build up and food particles on the floor in the corners, under the shelves, behind the door and around the door frame in the pantry. -There was dirt and dust buildup with numerous dead flies on the window sills in both dining rooms. -There was heavy scum buildup inside and around the hand washing sink in the kitchen. <p>Observations of the breakfast meal on 9/26/17 from 7:50am until 8:30am revealed:</p> <ul style="list-style-type: none"> -Residents were served the breakfast meal and as the residents finished, the plates were scraped into a garbage can by the service window between the dining room and kitchen. -Groups of five residents were seated into the 	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 282	<p>Continued From page 116</p> <p>same seat and table space where a resident had just finished eating. -The tables were not cleaned between residents.</p> <p>Interview with a Medication Aide (MA) on 9/26/17 at 5:15pm revealed she had seen the drip marks on the walls, dirt and dust accumulations at the edges and corners of the floors and dead flies in the window sills of the dining rooms, but had not reported it to anyone.</p> <p>Interview with a cook on 9/25/17 at 4:45pm revealed: -The cooks were responsible for cleaning the kitchen. -Two weeks ago the cooks had done extra cleaning and wiped down the appliances, stove and prep areas. -The cooks worked in the kitchen by themselves and it was usually just one cook. -There was no dietary aide. -The Personal Care Aides (PCAs) helped to serve the meals in the dining room. -The cook was responsible for cooking for 74 residents in the facility and also made lunch for an outside day program which had 30 people on Mondays, Tuesdays, Thursdays and some Fridays. -It was difficult for one person to cook, serve and clean. -The AOM was aware that the kitchen and dining room were not cleaned well because "he knew there was just one cook working in the kitchen."</p> <p>Interview with a second cook on 9/25/17 at 5:00pm and 9/28/17 at 12:09pm revealed: -His priority was to cook and serve the meals and there was not enough time to clean the way the cooks were supposed to. -Residents who participated in the Activity Work</p>	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 282	<p>Continued From page 117</p> <p>Program cleaned the dining room tables after each meal.</p> <p>Interview with a housekeeper on 9/28/17 at 9:36am revealed: -He had worked at the facility as a housekeeper for one month. -When there was no kitchen staff, one of the housekeepers would work in the kitchen leaving just one housekeeper to clean. -A housekeeper would have to work in the kitchen two out five days Monday through Friday on average each week. -The housekeeper would "just help out in the kitchen." -The Housekeeping Supervisor was aware there were not enough housekeepers to clean and cover in the kitchen and had talked to the Assistant Operations Manager (AOM).</p> <p>Interview with the Housekeeping Supervisor on 9/27/17 at 4:19pm revealed: -The housekeepers were "shorthanded, always shorthanded." -The housekeepers had been working with just one person for "a long time." -The housekeeping staff had just become a "full crew" about three weeks ago. -He declined to answer any further questions.</p> <p>Interview with the AOM on 9/28/17 at 3:30pm revealed: -He was responsible for overseeing the activity program, the kitchen, housekeeping and maintenance and reported to the Operations Manager (OM). -He was not aware of the dead flies on the window sills in the kitchen. -He did not check the kitchen as thoroughly as the resident rooms.</p>	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 282	Continued From page 118 -His main concern in the kitchen was that everything was stored properly and that the residents were served properly.	D 282		
D 286	<p>10A NCAC 13F .0904(b)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure sufficient staff for safe and sanitary food service including providing beverages, condiments, and additional servings; and serving food in an unrushed fashion; monitoring and assisting residents for safe meal consumption.</p> <p>The findings are:</p> <p>Review of the facility's Resident Listing/Census on 9/25/17 revealed a census of 71 residents.</p> <p>Observation of the empty main dining room on 9/25/17 at 4:24 pm revealed:</p> <ul style="list-style-type: none"> -There was a smaller attached dining room area. -There were 11 tables and 24 chairs in the main dining room. -There were 9 tables and 27 chairs in the adjoining smaller dining room. -The tables and chairs in the main dining room were cluttered with limited space between the tables and entrance way to the smaller adjoining dining room. 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 286	<p>Continued From page 119</p> <ul style="list-style-type: none"> -There was a door left open to the adjoining smaller dining room. -The tables and chairs covered approximately two-thirds of the dining room in both areas. <p>Observation of breakfast meal preparation/setup on 9/26/17 at 7:43 am - 8:05 am revealed:</p> <ul style="list-style-type: none"> -Each residents' place setting had a spoon and napkin only. -Nine residents were seated in the dining room waiting to eat. -There were no staff in the dining room areas. -The kitchen area door was locked. -There were 2 white medium sized containers half filled with blue cleaning solution under the food preparation and serving area. -There were two grayish cloths in the blue solution of one of the white medium sized containers. -The food preparation/serving area was covered with a dried white film. <p>Observation of breakfast meal on 9/26/17 at 8:10 am revealed:</p> <ul style="list-style-type: none"> -Milk and orange juice were served in 8-ounce plastic cups. -Food items were setup and served from the food preparation area over the two medium sized white containers half filled with blue cleaning solution. -Large metal spoons were used to serve the food items unto the sectioned plates. -All residents received the same sized portions of food. -The menu with specified portion sizes was not followed. -Two pink sweetener packets were placed on each plate of food. -There was a jug of milk and a pitcher of orange juice left on a small serving cart by the food 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 286	<p>Continued From page 120</p> <p>preparation area without ice.</p> <ul style="list-style-type: none"> -Each residents' plate was quickly made and placed on the counter above the food preparation area. -Residents were rushing through the line after getting their plate of food from the counter. -The place settings were not cleaned after each resident finished before the next resident was seated with their plate of food. -There was a line of 8 - 10 residents waiting to eat by the food preparation area. -The spaces between the table and chairs were narrow and limited; allowing one person at a time to walk through by turning sideways. -One person could walk between the tables when all the chairs were tucked under the tables and with no one sitting at the tables. -Two persons could pass through the entrance to the adjoining smaller dining room by walking through single file and by turning sideways when the tables and chairs were empty. <p>Interview with a cook on 9/26/17 at 8:30 am revealed:</p> <ul style="list-style-type: none"> -The meal service process was to have residents pick up their plates of food and their beverage as they came into the dining room. -Residents who were incapable of carrying their plate of food to their assigned seat were assisted by staff after the other residents had picked up their meal at the food preparation/serving counter. -There were normally two personal care aides assisting with the residents in the dining room during meals. -The facility only had one meal time for all of the residents. -The residents lined up to wait to get their food. -He wrote down each meal, every day and each meal depended on what was available in the 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 286	<p>Continued From page 121</p> <p>kitchen.</p> <ul style="list-style-type: none"> -He was instructed by the Dietary Manager to follow the daily handwritten menu. -The residents have told him they do not like the same food like rice and pork, but he had to serve what was available. -He served the residents large portions of food and gave pink packets of sweetener to the diabetics. -He was unaware of portion sizes or the dietician's menu. -He was not aware cleaning solutions and supplies could not be near food items. -He served water at lunch and supper meals or anytime a resident requested it. -All residents have a choice of beverages on the food preparation counter and could choose the beverages they wanted at each meal. -He had to prepare each plate quickly because he was the only staff person in the kitchen. -He didn't want to keep the residents waiting in line. -He washed the dishes and cleaned the kitchen area after the majority of the residents had finished eating. <p>Confidential interviews with nine residents revealed:</p> <ul style="list-style-type: none"> -They had to wait in the dining room for the kitchen to be opened to eat. -They sat in the dining room until it was time to eat. -The staff were not consistently in the dining room to respond to verbal requests of the residents. -The residents were dissatisfied with the lack of condiments available to them during meal times. -Residents complained they could not have salt and pepper available at all times on their dining room tables. -They were unable to get the attention of the staff 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 286	<p>Continued From page 122</p> <p>to serve condiments after they were served their plates of food, as the staff moved on to serve other residents.</p> <ul style="list-style-type: none"> -Large portions of food were always served so we don't need seconds. -Staff would give us more food if we asked. -The food was not good most of the time. -The dining room was crowded and loud the majority of the time. -Most of the time there was only one staff in the dining room to help pass out the plates of food. -They felt "rushed" because they had to finish to make room for the other residents to eat their food. -They had to hurry up and eat because the other residents were lined up and waiting. -Their tables were never cleaned or wiped off. -They only got water during the lunch and supper meals. -Staff would give them water if they asked for it. <p>Observation of the kitchen preparation area on 9/26/17 at 12:26 pm revealed the food preparation area had been cleaned and two containers half filled with cleaning supplies had been removed.</p> <p>Confidential interviews with five residents revealed:</p> <ul style="list-style-type: none"> -The dining room was a little crowded most of the time. -There was not enough space for everyone to eat at the same time. -The residents did not want to complain but they would like more time to enjoy their food. -Staff were busy helping other residents on the floor who were having behavior episodes and could not help in the dining room. -The Cook did everything in the kitchen by himself. That's why he had to move fast to fix all 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 286	<p>Continued From page 123</p> <p>of those plates.</p> <ul style="list-style-type: none"> -They had a better chance of getting personal requests such as condiments and additional beverages met at the end of a meal, as the cook was too rushed to get all the plates served to the other residents. -They would like second helpings, but the staff were too busy to get them additional food. -The facility staff appeared to not hear them when they requested additional food and beverages. -Their tables were dirty and not cleaned. -The food was okay but they got the same foods the majority of the time such as rice and pork. <p>Observation of the lunch meal on 9/26/17 at 12:30 pm revealed:</p> <ul style="list-style-type: none"> -Milk, unsweetened tea, and water were prepared in plastic cups placed on a tray on the food preparation area counter. -The dining room was crowded with very little room to walk through the two adjoining dining rooms. -The dining areas were noisy. -There were 10-12 residents lined up by the food preparation area waiting to eat. -A large serving spoon was used for each of the food items. -Portions of food were quickly "plopped" on each plate. -The tables were not cleaned after each resident had finished eating. -One resident asked for help with getting seconds of food. -There were two staff picking up plates of food and serving them to the residents in wheelchairs at the dining room tables. -Fourteen residents were not offered or served water. <p>Observation of the lunch meal on 9/27/17 at</p>	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 286	<p>Continued From page 124</p> <p>12:30 pm revealed:</p> <ul style="list-style-type: none"> -Ten to twelve residents were lined up by the dining room entrance waiting to eat. -A cook was preparing plates in a rushed manner. -One resident was upset about having to wait in line to eat because he tried to move ahead of the line of residents. -A cook was assisting in the dining room area and another cook was preparing the resident plates of food in a rushed manner. -One white medium sized container with blue cleaning solution and a grayish cloth in it was under the food preparation/serving area. -One staff was walking quickly from the main dining room to the smaller adjoining dining room while turning sideways to walk through. -The dining room area was crowded with limited space for residents to move their wheelchairs or walk by other residents. -Place settings were not cleaned between resident's use after they had finished eating. -Beverage choices of water, milk, and pink colored drink were in plastic cups located on the counter of the food preparation area. -The majority of the residents in the smaller adjoining dining room were not served or offered water. <p>Attempted interview with a second Personal Care Aide (PCA) in the dining rooms assisting on 9/27/17 at 12:47 pm was unsuccessful as the PCA declined the interview.</p> <p>Interview with a third Personal Care Aide (PCA) on 10/02/17 at 1:21 pm revealed:</p> <ul style="list-style-type: none"> -There was usually a long line of 10 - 12 residents at mealtimes waiting to eat. -Sometimes most of the residents were seated in the dining room area before the meals started. -There were usually three facility staff available to 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 286	<p>Continued From page 125</p> <p>assist during mealtimes with two staff in the dining room and one staff on the floor to monitor the residents in line waiting to eat.</p> <p>Interview with a second cook on 9/28/17 at 12:09 pm revealed:</p> <ul style="list-style-type: none"> -He followed the daily handwritten menu to prepare meals. -He wanted to make sure each resident had good sized portions of food to eat. -Residents were provided a choice of beverages including water at each meal. -He was unaware cleaning supplies must be stored and kept away from food items. -He tried his best to get the residents in and out of the dining room so they would not have to wait too long before eating. -He cleaned the best he could after the residents had eaten. <p>Interview with Operations Manager/Dietary Manager on 9/28/17 at 3:30 pm revealed:</p> <ul style="list-style-type: none"> -He served as the Dietary Manager of the facility. -The residents had the opportunity to voice likes and dislikes regarding the food during their monthly self-advocacy meetings. -With seventy plus residents, they were not going to like everything served, all of the time. -All residents were offered sandwiches as substitutes. -He did not check the dining rooms and kitchen areas as often as he liked to ensure those areas were cleaned. -He expected the kitchen and dining areas to be cleaned daily. -He was unaware the dining room tables were not being cleaned after each resident. -He did not know cleaning supplies were not to be stored with resident food items. -He would correct that immediately and inform the 	D 286		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 286	<p>Continued From page 126</p> <p>dietary staff.</p> <ul style="list-style-type: none"> -A meeting to discuss the possibility of a second dining would be held with management to help with the long lines during mealtimes. -There were usually 1-2 cooks in the kitchen each day. -He was not aware the residents had concerns about not getting condiments. -He ordered condiments and other food items weekly and/or as needed. <p>Interview with Administrator on 9/28/17 at 4:45 pm revealed:</p> <ul style="list-style-type: none"> -She was not aware of the resident concerns regarding the food, beverages, and mealtimes. -She would follow-up with the Dietary Manager regarding any concerns. 	D 286		
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents received a place setting consisting of a knife, fork and spoon for all residents residing in the facility.</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 287	<p>Continued From page 127</p> <p>The findings are:</p> <p>Observation of breakfast meal preparation and setup on 9/26/17 at 7:43am - 8:05am revealed each residents' place setting had a spoon and napkin only.</p> <p>Observation of the facility dining room on 9/26/17 at 12:30pm revealed the place settings on the dining room tables consisted only of a napkin and a spoon.</p> <p>A. Observation of Resident #1 at 12:40pm on 9/26/17 in the dining room revealed: -The resident's plate contained a breaded beef patty, mixed vegetables of peas and carrots, fruit cocktail, potato wedges, and a slice of whole wheat bread. -Resident #1 had only a spoon to eat with, and was observed during the meal from 12:40pm to 1:03pm to eat the beef patty with her hands. -The resident used the spoon to eat 50% of her mixed vegetables and potatoes, and 90% of her fruit cocktail.</p> <p>Interview with Resident #1 at 12:45pm on 9/26/17 revealed: -They only received a spoon to eat with at all their meals. -She had asked the kitchen staff for a fork, but was told it could be used as a weapon. -The resident stated "it would be nice to have a fork, it's hard to eat spaghetti with only a spoon."</p> <p>Review of Resident #1's physician's orders revealed: -A standardized form with the resident's name, date, physician's signature and date signed. -The form documented, "State regulations requires this facility to use a complete place</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 287	<p>Continued From page 128</p> <p>setting consisting of a knife, fork, and spoon. With a mentally ill resident, a fork or a knife can be used as a weapon. The following physician's order allows the resident to have only a spoon at each meal."</p> <p>-The form was signed and dated by the resident's primary care provider, a Nurse Practitioner(NP), on 9/7/17.</p> <p>Review of Resident #1's record revealed: -Diagnoses included encephalopathy, diabetes, and bipolar disorder. -No documentation Resident #1 was unsafe with a knife or fork, or had violent tendencies.</p> <p>Interview with staff (Med Office Assistants for both NPs and the lead NP) at the primary care provider's office on 10/2/17 at 9:50am revealed: -The Nurse Practitioner (NP) does an assessment on all residents before he signs the order for them to have only a spoon at a place setting. -Any specific notes about residents being unsafe with a knife or fork should be in their record. -The forms used for the place setting are generic but would not have been completed without an individual assessment on each resident. -Not all residents are safe with a knife and fork, some are violent (no specific residents named.)</p> <p>Refer to interview with a resident on 9/25/17 at 5:11pm.</p> <p>B. Review of Resident #15's current FL2 dated 6/15/17 revealed a diagnoses included dementia secondary to Parkinson's, chronic obstructive pulmonary disease (COPD,) osteoarthritis and hypothyroidism.</p> <p>Observations on 9/26/17 from 8:05 am until 8:30</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 287	<p>Continued From page 129</p> <p>am of Resident #15 eating breakfast revealed: -Resident #15 received a cup of coffee, a cup of orange juice, eggs, grits, bacon and one slice of bread for the breakfast meal. -Resident #15 prepared her bread with jelly, added sweetener to her coffee and ate her meal without assistance from staff. -Resident #15 used her fingers to eat the bacon. -Resident #15 used her fingers to push the food onto the spoon. -Resident #15 hands were shaking and the food was falling off of the spoon.</p> <p>Observation on 9/26/17 at 12:30 pm to 1:05 pm of Resident #15 eating lunch revealed: -Resident #15 received a cup of water, tea and milk, beef steak, potato wedges, mixed vegetables, fruit and bread. -There was no feeding assistance throughout the entire meal. -Resident #15 used her fingers to push the food onto the spoon. -Resident #15 hands were shaking and the food was falling off of the spoon. -Resident #15 picked up her beef patty with her hands to eat. Her hands were shaking the whole time. -Resident #15 consumed 25% of meal.</p> <p>Interview on 9/28/17 at 9:00 am with Resident #15 revealed: -Her tremors are so bad at times, her food falls off of her spoon and was difficult for her to eat. -No one helps her with eating, "I could eat more" if the staff would help. -She was not aware that the staff was to help her with feeding assistance.</p> <p>Refer to interview with a resident on 9/25/17 at 5:11pm.</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 287	<p>Continued From page 130</p> <p>C. Review of Resident #2's current FL-2 dated 5/31/17 revealed diagnoses included Major Depression with Suicidal Ideation.</p> <p>Review of Resident #2's care plan dated 10/19/16 revealed: -The resident needed supervision with meals. -There was no documentation the resident was unable to use or would aggressively misuse a fork and/or knife.</p> <p>Based on observations, interviews and record reviews, Resident #2 was not interviewable due to aphasia.</p> <p>Observation on 9/25/17 at 10:32am revealed: -Resident #2 entered the smoking area outside from the entrance near the facility's medication room. -Resident #2 propelled the wheelchair forward using his left foot and left hand. -Resident #2's was unable to move his right arm except to pick the arm up with his left hand.</p> <p>Observations of the breakfast meal on 9/26/17 from 7:50am until 8:30am revealed: -Resident #2 was served at grits, eggs, bacon and one slice of bread at 8:08am. -He ate 100% of the breakfast meal using a spoon by 8:19am.</p> <p>Observations of the lunch meal on 9/26/17 from 12:34pm until 1:05pm revealed Resident #2 was not in the dining room.</p> <p>Interview with Resident #2 on 9/26/17 at 1:05pm revealed he shook his head "no" in response to wanting to eat lunch.</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 287	<p>Continued From page 131</p> <p>Refer to interview with a resident on 9/25/17 at 5:11pm.</p> <p>Refer to interview with a second resident on 9/26/17 at 4:45pm.</p> <p>Refer to observations of the lunch meal on 9/26/17 from 12:34pm until 1:05pm.</p> <hr/> <p>Interview with a resident on 9/25/17 at 5:11pm revealed: -She participated in the Activity Work Program and her job was to set the tables for each meal. -She was instructed to put a napkin, a spoon, a salt packet and a pepper packet at each place setting. -None of the residents got a fork or a knife for any meal.</p> <p>Interview with a second resident on 9/26/17 at 4:45pm revealed the resident wanted to be able to use a knife and a fork to eat meals at the facility.</p> <p>Observations of the lunch meal on 9/26/17 from 12:34pm until 1:05pm revealed: -Residents were served breaded beef steaks, mixed vegetables, potato wedges and fruit cocktail. -There were five residents eating the breaded beef steak with their hands. -There was only one resident who was served a cut up breaded beef steak. -The PCA assisted another resident with cutting up the breaded beef steak.</p>	D 287		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service	D 312		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 312	<p>Continued From page 132</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide assistance with meals that promoted dignity and respect for 1 of 1 sampled residents (#15) with a diagnosis of dementia and Parkinson's, who needed assistance in the dining room during two meal observations.</p> <p>The findings are:</p> <p>Review of Resident #15's FL2 dated 6/15/17 revealed: -Diagnoses included dementia secondary to Parkinson's, chronic obstructive pulmonary disease, osteoarthritis and hypothyroidism. -Disorientation was documented as "constantly". -Her personal care assistance she required was documented as bathing, feeding and dressing.</p> <p>Review of Resident #15's physician's order dated 6/22/17 revealed staff to assist with feeding resident at all meals.</p> <p>Review of Resident #15's Care Plan dated 6/27/17 revealed: -She required total assistance with eating and bathing. -She required limited assistance with toileting, dressing and grooming.</p>	D 312		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 312	<p>Continued From page 133</p> <p>-She required supervision with ambulation and transfer. -She ambulated with a rolling walker and needs reminders.</p> <p>Observations on 9/26/17 from 8:05 am until 8:30 am of Resident #15 eating breakfast revealed: -Resident #15 received a cup of coffee, a cup of orange juice, eggs, grits, bacon and one slice of bread for the breakfast meal. -Resident #15 prepared her bread with jelly, added sweetener to her coffee and ate her meal without assistance from staff. Resident #15 used her fingers to eat the bacon. -Resident #15 used her fingers to push the food onto the spoon. -Resident #15 hands were shaking and the food was falling off of the spoon.</p> <p>Observation on 9/26/17 at 12:30 pm to 1:05 pm of Resident #15 eating lunch revealed: -Resident #15 received a cup of water, tea and milk, beef steak, potato wedges, mixed vegetables, fruit and bread. -There was no feeding assistance throughout the entire meal. -Resident #15 used her fingers to push the food onto the spoon. -Resident #15 hands were shaking and the food was falling off of the spoon. -Resident #15 picked up her beef patty with her hands to eat. Her hand were shaking the whole time. -Resident #15 consumed 25% of meal.</p> <p>Review of the facility's diet list dated 8/15/17 revealed Resident #15 was listed for a regular diet and "staff to assist with feeding at meals."</p> <p>Interview on 9/28/17 at 9:00 am with Resident</p>	D 312		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	<p>Continued From page 134</p> <p>#15 revealed: -Her tremors are so bad at times, her food falls off of her spoon and was difficult for her to eat. -No one helps her with eating, "I could eat more" if the staff would help. -She was not aware that the staff was to help her with feeding assistance.</p> <p>Telephone interview on 9/28/17 at 3:00 pm with Resident #15 Primary Care Provider revealed Resident #15 needed feeding assistance with all meals because of the tremors.</p>	D 312		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure residents were not threatened by a staff (Staff I) who carried a utility knife at work; verbally threatened by a staff (Staff E); and that residents were not spoken to in a dismissive, sharp, provoking and disrespectful manner by staff.</p> <p>The findings are:</p> <p>A. Interviews with Resident #4 on 9/27/17 at 1:44pm and 6:30pm revealed:</p>	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/02/2017
NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28751			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	PES COMPLETE DATE	
D 338	<p>Continued From page 135</p> <ul style="list-style-type: none"> -She witnessed Staff I pull out a knife on several residents including her, on a daily basis when Staff I started working at the facility a couple of years ago. -Staff I was joking around with residents and the joking "went too far" when Staff I pulled out a knife and said to the residents, "What are you going to do now?" -One of the other residents was no longer at the facility and the other residents' names were hard to remember. -Staff I was rehired after he pushed or punched a resident for calling him a [racial slur] in the spring of 2017. -It did not take Staff I long "to get back to his old behaviors" meaning he pulled out a pocket knife out on the resident within the last month to three months. -Staff I had a black and silver "flip knife," not a plastic knife, not a kitchen knife and not a box cutter. -She felt unsafe at the facility because she knew Staff I had a knife and threatened her with it. -The resident did not report the incident to staff because the resident felt the facility did not do anything about resident complaints. <p>Confidential interview with a staff revealed:</p> <ul style="list-style-type: none"> -There were staff that should not be working at the facility and Staff I was one of them because of how he talked to residents. -Staff I treated some residents special and yelled at others. -Staff I would say things like, "Get your [explicit] out of here. We don't want to see you. Just go. Get out." -One of the residents Staff I said things like that to was Resident #1B. -Staff I did carry a utility knife. -Staff had not seen Staff I threaten a resident with 	D 338	<p>Amended 12/14/17</p> <p>Because several facility residents have disabilities including symptoms of mental illness, the facility felt that our staff would benefit from additional training on understanding mental illness and common steps to de-escalate negative behaviors. Toward this goal, the facility contracted for certified "MindSet" level 1 training (broken into two parts to make it easier for non-mental professionals to absorb the material) from MindSet Consulting Services, LLC of Asheville, NC. This training includes the purpose to facilitate insight, raise awareness, and enhance skills of care givers to manage difficult and/or aggressive behaviors from the symptoms of mental illness. These classes will begin December 2017 and will continue through</p>	11/1/17	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2017
NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1257 PINNACLE CHURCH ROAD NEBO, NC 28761		
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D 338	<p>Continued From page 136</p> <p>the utility knife.</p> <p>Interview with Staff I on 9/27/17 at 4:19pm revealed:</p> <ul style="list-style-type: none"> -He carried a metal pocket knife, but it was not on his person when he was at work. -It was a box cutter that he kept in his pocket to open boxes at the facility. -He declined to clarify whether it was a knife or a box cutter and whether or not he kept the knife/box cutter in his pocket. -He had never shown anyone the knife, but someone might have seen it. -He had never threatened a resident with the knife. -He "did not need a knife to defend himself." -He was not answering anymore questions. <p>Observations during Staff I interview on 9/27/17 at 4:19pm revealed:</p> <ul style="list-style-type: none"> -Staff I did not make eye contact. -Staff I was looking at his phone and moving away for the duration of the interview. -Staff I responded in a sharp and dismissive tone of voice. <p>Interview with the Assistant Operations Manager (AOM) on 9/27/17 at 5:48pm revealed:</p> <ul style="list-style-type: none"> -He knew where Staff I had gotten a knife from. -On 9/27/17, the facility kitchen had an inspection and were told to remove cutlery left by a former employee. -On 9/27/17, the AOM had the cutlery in his office and offered staff to take home whatever they wanted. -He did not know about any previous instances. <p>Interview with the AOM on 9/29/17 at 12:27pm revealed:</p> <ul style="list-style-type: none"> -He was able to assure the Administrator Staff I 	D 338 contd.	<p>January 2018 and on an ongoing basis with the goal to have all employees complete both parts, with annual refresher classes.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 137</p> <p>did not have a knife because he had Staff I empty his pockets on arrival to work. -He also checked Staff I's key ring because the AOM knew that was where he normally kept his box cutter. -Staff I did not have a knife or a box cutter. -The AOM instructed Staff I not to bring his box cutter to work until "this was all over."</p> <p>Interview with the Administrator on 9/27/17 at 5:50pm and 9/28/17 at 3:15pm revealed: -She was not aware of any allegations of Staff I bringing a knife to work at any time. -She had completed a Health Care Personnel Registry Report (HCPR) on Staff I and contacted the local law enforcement when she learned a resident alleged being threatened. -An Adult Protective Services worker and the local police department had been to the facility to initiate investigations. -The AOM had met with Staff I the morning of 9/28/17 and assured the Administrator that Staff I did not have a knife, a box cutter or anything like that. -Staff I was permitted to return to work on 9/28/17 during the investigation because there was only Resident #4's word against Staff I's word and there was no evidence. -The facility did not have a written policy on conducting investigations of allegations of threats or abuse and the criteria for suspension of staff with allegations of abuse. -Whether or not staff was suspended or not during the facility's investigation depended on the circumstances and determined on an individual basis. -She did not feel Staff I posed a threat to residents in the facility. -Staff I had been suspended from work for a previous incident in which he grabbed and</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 138</p> <p>shoved a resident from the common area into the medication room because the resident was threatening a staff. -The HCPR had "cleared Staff I," meaning the allegations were unsubstantiated and he returned to work.</p> <p>B. Review of Resident #3's current FL-2 dated 5/16/17 revealed diagnoses included Muscle Weakness, Cutaneous Weakness, Schizophrenia and Bipolar Disorder.</p> <p>Review of a emergency room report for Resident #3 dated 8/24/17 revealed under the history of present illness Resident #3 was seen after being found on the floor, had a history of seizures and presented with a subtherapeutic Dilantin level. (Dilantin is used to treat seizures.)</p> <p>Review of an untitled and undated document for Resident #3 revealed there was a typed note with Resident #3's name indicating the resident wore a magnetic bracelet that was a Vagus Nerve Stimulator. (A Vagus Nerve Stimulator is an implanted device used with an external bracelet to prevent a seizure.)</p> <p>Review of Resident #3's current care plan dated 6/1/17 revealed: -Staff documented Resident #3 was re-admitted to the facility in May 2016 following rehabilitation at a skilled nursing facility. -Resident #3 had a guardian and was receiving mental health services. -Resident #3 "got along well with others most of the time, enjoyed socializing and participated in facility activities." -If Resident #3 was anxious or agitated, staff should talk to her in a calm tone and offer as needed medication (PRN).</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 139</p> <p>-Staff should contact the mobile crisis team if the PRN was not effective.</p> <p>Interview with Resident #3 on 9/18/17 at 3:30pm revealed: -Staff E liked to argue with me and had threatened to fight me. -Staff E threatened to "whoop my [explicit]" about two months ago. -She was arguing with Staff E over incontinence briefs at the supply closet and Staff E waved a plunger at me. -She just stopped arguing with Staff E and left the supply closet.</p> <p>Confidential interviews with a resident revealed: -Staff E, Staff F and Staff C had fought with Resident #3. -Resident #3 was on the floor saying she had a seizure and the staff just kept telling the resident to get up. -Resident #3 said she could not get up at that moment because her legs were "bad." -Staff E, Staff F and Staff C were grabbing and pulling Resident #3 over some medication that Resident #3 did not want to take. -It was because of how staff treated Resident #3 that Resident #3 ended up in the hospital.</p> <p>Resident #3 was hospitalized on 9/20/17 and was not available for interview from 9/25/17 through 10/2/17.</p> <p>Attempted interview with Resident #3's Guardian on 10/2/17 at 10:17am was unsuccessful.</p> <p>Interview with Staff C on 9/26/17 at 3:31pm revealed: -She had an altercation with Resident #3 where the resident had grabbed her, tried to choke</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 140</p> <p>another staff, threw a table at the back of another resident's chair and broke a dining room window. -She moved the other resident out of the way so no one was hurt. -Resident #3 just stopped and was calm after that. -She could not remember when this happened, but knew it was just prior to Resident #3 being Involuntarily Committed (IVC'd). -She did not see all of the events that led to Resident #3 being IVC'd. -She had seen Resident #3 in the hallway yelling at the Operations Manager (OM), then the resident threw a package of incontinence briefs at the OM and Staff E was standing at the closet and had a plunger. -She was unable to provide any further information on what happened between Staff E and Resident #3.</p> <p>Interview with Staff F on 9/26/17 at 5:15pm revealed: -She was not at work when Resident #3 was sent to the hospital on 9/20/17. -The last time she worked with Resident #3 was (9/19/17) and on that evening Resident #3 "was going off." -Resident #3 put herself on the floor, started blinking her eyes and then sat back up in the chair. -Resident #3 thought staff thought the resident was faking seizures so the resident went to the dining room and knocked the whole table of snacks over. -There were no residents in the dining room, there was only staff. -She had never mistreated or spoke disrespectfully to any resident.</p> <p>Interview with Staff E on 9/26/17 at 5:00am</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 141</p> <p>revealed:</p> <ul style="list-style-type: none"> -She was getting incontinence briefs for Resident #3 about a month ago and was getting the resident her "ordered size" which was medium. -Resident #3 started arguing with Staff E that that was not her size, they were supposed to be a large. -Resident #3 started "cussing and fussing" with Staff E about the incontinence briefs. -She tried to diffuse Resident #3 and ended up walking away from Resident #3. -Two weeks ago (9/12/17), Resident #3 tried to hit Staff E with a fire extinguisher and was IVC'd for that. -Resident #3 was known to have severe behavior. -Resident #3 had "busted out a window in the dining room" about two to three months ago; and assaulted Staff E and choked Staff C and a Medication Aide (MA). -No residents were injured and local law enforcement was called. <p>Interview with a Medication Aide (MA) on 9/28/17 at 10:28am revealed:</p> <ul style="list-style-type: none"> -An incident that occurred just prior to Resident #3 being IVC'd (9/20/17) started on the 3rd shift. -The MA on duty and Resident #3 called Mobile Crisis at 1:00am on 9/20/17. -Resident #3 was complaining about getting the wrong vaginal cream. -Resident #3 talked with Mobile Crisis on the phone, was on 15 minute checks until Mobile Crisis arrived the afternoon of 9/20/17, and there were no further incidents between 1:00am and the time the resident left the facility. -The dining room incident with Resident #3 attempting to choke a staff was a separate incident that happened in August 2017. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 142</p> <p>Review of Charting Notes for Resident #3 dated 8/6/17 through 9/20/17 revealed:</p> <ul style="list-style-type: none"> -On 8/6/17, staff documented that Resident #3 returned from the emergency room, laid herself down on the floor in the dining room and yelled for staff to check her blood sugar. -Ten minutes later, Resident #3 started throwing chairs, flipping tables, hitting staff and trying to choke a Medication Aide (MA). -Resident #3 was IVC'd on 8/6/17. -On 9/5/17, staff documented that Resident #3 was IVC'd for threatening self-harm and wrapping her pocket book around her neck. -On 9/20/17, staff documented that the mobile crisis team had responded at 8:00am to an incident involving Resident #3 with increased paranoia, agitation and threats to harm herself. -There was no documentation of the incident involving Staff E and Resident #3, what was done about it and who was notified. <p>Review of "Accident/Injury Reports" for Resident #3 dated 6/21/17 through 9/20/17 revealed there was no report for an incident involving Staff E and Resident #3.</p> <p>Review of Resident #3's electronic Medication Administration Record (eMAR) for September 2017 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Fluphenazine 5mg every six hours as needed for anxiety and agitation. (Fluphenazine is an antipsychotic used to treat psychosis.) -There was documentation one dose was administered 9/19/17 at 4:47pm and was effective. -There was an entry for Lorazepam 0.5mg every six hours as needed for anxiety and agitation. (Lorazepam is a benzodiazepine used to treat anxiety.) 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CEDARBROOK RESIDENTIAL CENTER 1267 PINNACLE CHURCH ROAD
NEBO, NC 28761

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D 338	<p>Continued From page 143</p> <ul style="list-style-type: none"> -There was documentation doses were administered on 9/19/17 at 1:23am, 9/19/17 at 8:21pm and were effective. -There were no doses documented as administered after 9/19/17 at 8:21pm. <p>Interview with the Mental Health Crisis Team Nurse (MHCTN) on 9/29/17 at 10:02am revealed:</p> <ul style="list-style-type: none"> -Resident #3 felt depressed and frustrated because she felt she was having seizures that staff could not see and therefore did not believe her. -Overall Resident #3 felt she was not heard and not believed. -She spoke with staff and Resident #3 overnight 9/19/17 - 9/20/17. -Staff reported that Resident #3 was on the floor claiming to have had a seizure. -Staff reported there was no seizure activity and helped Resident #3 up off of the floor. -Resident #3 then went to the dining room and threw some milk off of the table, returned to her room and was calm and quiet until the MHTTN arrived at the facility on 9/20/17. -She did not remember which staff had contacted her. -She had also received a text overnight 9/19/17 - 9/20/17 that Resident #3 reported being given vaginal cream that was not the resident's. -She spoke with Resident #3 overnight on 9/19/17 - 9/20/17. -The last call she received was documented in the note dated for 9/20/17. <p>Review of the crisis response call note dated 9/20/17 for Resident #3 revealed:</p> <ul style="list-style-type: none"> -Resident #3 was in the dining room eating breakfast at the time of the assessment. -Resident #3 reported having seizures with associated incontinence while she was sleeping. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 144</p> <p>-Resident #3 was depressed and experiencing anxiety because of the seizures and incontinence. -Resident #3 verbalized suicidal thoughts and plans and was therefore IVC'd.</p> <p>Interview with the Mental Health Treatment Team Nurse (MHTTN) on 9/29/17 at 10:15am revealed: -Resident #3 did not initially have aggressive behaviors and really wanted to "engage with staff" to work on accepting her diagnosis and coping skills. -If Resident #3 did not feel heard, she did present with more aggression and the resident had been having increased symptoms over the last couple of months because she felt unheard. -Resident #3 had reported that staff were rude and disrespectful in how they talked to residents. -Staffs rudeness was directed at Resident #3's medical complaints where Resident #3 felt dismissed. -Resident #3 had not reported being threatened by staff. -She had heard about Resident #3 throwing incontinence briefs at staff, but was not aware staff threatened to "whoop her [explicit.]" -The throwing of incontinence briefs happened approximately three weeks to a month ago (8/29/17 - 9/4/17). -She did not negate what residents reported just because they have a mental health diagnosis and felt staff could benefit from more education on dealing with residents individually that have a mental health diagnosis because the residents were not all the same.</p> <p>Telephone interview with Resident #3's Mental Health Provider (MHP) on 10/2/17 at 4:20pm revealed she was not aware of any incidents involving staff threatening the resident.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 145</p> <p>Interview with the Operations Manager (OM) on 9/29/17 at 12:27pm and 10/2/17 at 2:39pm revealed:</p> <ul style="list-style-type: none"> -She was not aware of any resident being threatened, cursed at or spoken to in a rude and disrespectful manner. -She was not aware Staff E threatened Resident #3 until she was informed by a surveyor. -She heard commotion out in the hall from her office and Staff E reported Resident #3 was giving her a hard time so the OM intervened to try and calm things down. -Staff E and Resident #3 were arguing over the size of the incontinence briefs Resident #3 was supposed to have. -Staff E was standing in the storage closet and Resident #3 started throwing packaged incontinence briefs. -Supposedly, Staff E threatened to "whoop" Resident #3 when they were standing in the closet. -She did not hear Staff E threaten Resident #3 and was not aware of it until after the fact. -The incident involving Staff E and Resident #3 occurred approximately three weeks ago (9/8/17). -Once she was aware, the Administrator was notified and a Health Care Personnel Registry Report (HCPR) was completed. -She and the Administrator conducted an investigation and completed the five day HCPR. <p>C. 1. Confidential interviews with a resident revealed:</p> <ul style="list-style-type: none"> -Staff would say things like, "Sit your [explicit] down. Don't get up. Pull your [explicit] clothes up, you see they are falling off your [explicit]. Eat your [explicit] food in front of you, you all are so greedy. Don't you see these [explicit] people, go around them." -Staff C and Staff E talk bad to residents and had 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 146</p> <p>pet residents they would allow to also talk bad to other residents.</p> <ul style="list-style-type: none"> -Staff C and Staff E would allow other residents to call residents names and make racial slurs. -Staff C and Staff E talked like this to residents on a regular basis. -Everybody knew how Staff C and Staff E talked to residents. <p>Telephone interview with a Medication Aide (MA) on 10/2/17 at 10:40am revealed:</p> <ul style="list-style-type: none"> -Most of the time staff may get a little short with residents because they were tired or a resident yelled and cursed at the staff. -She was usually the Supervisor on duty and would therefore address any issues herself. -If she saw staff being short with residents, she would remind them of why they were all there which was for the residents. -She was not aware of anything "major" happening between staff and residents. -If a resident had been mistreated by a staff, she would address it herself and report the incident to the Operations Manager (OM). <p>Interview with the OM on 10/2/17 at 2:39pm revealed:</p> <ul style="list-style-type: none"> -She was not aware of any complaints about Staff C and Staff E. -There was one resident complaint about Staff F being rude and disrespectful toward a resident. -She had investigated the complaint and felt the resident had delusional thoughts about Staff F. <p>2. Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> -The 2nd and 3rd shift staff would speak disrespectfully to and curse at residents. -Staff would say things like "They (a resident) was wearing the same raggedy clothes. Nobody wants to see your [explicit] anymore." 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES-- AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 147</p> <ul style="list-style-type: none"> -Sometimes it was not what the staff were saying, but how they were saying it. -For example, "You know you don't sit here in the dining room," when a resident sat at the wrong table for a meal. -The demeanor in the dining room with how staff talked to residents was "just disrespectful period." -Staff sit outside talking "smack" about residents. -Management had to do something with the 3rd shift, they were all "bad apples." <p>Confidential interview with a staff revealed 2nd and 3rd shift staff would say things to residents to "get them going," meaning to provoke the residents because the staff thought it was funny.</p> <p>Confidential interview with a second staff revealed staff were sharp in the tone they used to address residents.</p> <p>Interview with the Administrator on 9/28/17 at 3:15pm revealed she could not think of any specific incidents of staff speaking rudely or disrespectfully to residents at this time and would have to consult the OM.</p> <p>Interview with the OM on 10/2/17 at 2:39pm revealed:</p> <ul style="list-style-type: none"> -She had not received and reports from residents or staff about staff talking to residents disrespectfully or cursing at residents. -She had not received any reports from staff or residents about staff mistreating any residents. <p>3. Observations on 9/27/17 at 12:43pm revealed:</p> <ul style="list-style-type: none"> -The main dining room was full with residents eating lunch, picking up lunch to sit down to eat and getting up to empty plates in the garbage can. -There were two Personal Care Aides (PCAs) 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 148</p> <p>assisting groups of five residents who had been waiting in line with getting plates of food and sitting down as well as residents already in the dining room.</p> <p>-There were two cooks plating the food for the residents.</p> <p>-Resident #5 started yelling in line "They won't let me have a sandwich. I'm not eating that again. We ate that other day. It's not fresh. It's nasty."</p> <p>-One of the cooks responded to Resident #5 that the food was fresh and that he "wasn't making anything else."</p> <p>-Resident #5 began to repeat his statements louder in an increasingly aggressive tone and left the line moving to the front of the line at the entrance to the dining room.</p> <p>-Other residents in line became restless and began moving out of line and looking in the dining room.</p> <p>-The two cooks put the food onto the plates and dropped the plates onto the top of the serving cart in a haphazard manner.</p> <p>-Residents were corralled through from the waiting to be seated line, to the pick up your plate and drinks line, to sitting at the table and eating, and then to empty their plates in a continuous stream.</p> <p>-One of the cooks shouted to Resident #5 "be quiet," then said, "I don't know why you acting this way now. I know what I'm going to do. You're not going to work with me no more since you want to act like that."</p> <p>-A PCA redirected Resident #5 away from the front of the line.</p> <p>Observations on 9/28/17 at 3:46pm revealed:</p> <p>-A resident interrupted an interview in progress in the Assistant Operations Manager's (AOM's) office and excitedly told the AOM about a birthday party.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 338	<p>Continued From page 149</p> <p>-The AOM responded, "So why are you telling me. I don't have anything to do with that," in a short and dismissive tone.</p> <p>-The AOM closed the door to his office with the resident standing in the doorway.</p> <p>Interview with the AOM on 9/28/17 at 3:46pm revealed:</p> <p>-There were frequent interuptions with residents requesting things from him.</p> <p>-The facility census had increased from 40 residents last year to 74 residents and he now recognized the need to make some changes to decrease the congestion and chaos around meals.</p> <p>-He was going to consider adding another meal time to decrease the stress on residents and staff.</p> <p>Interview with the Administrator on 9/28/17 at 3:15pm revealed:</p> <p>-The Operations Manager (OM) usually dealt with complaints of staff saying things they shouldn't.</p> <p>-The OM usually started out talking with staff and if the complaint was made by another staff, the OM would talk to the staff and resident.</p> <p>Interview with the Owner on 9/29/17 at 6:00pm revealed it was the law to uphold residents' rights including treating residents with respect and dignity and assuring residents were not abused or neglected.</p> <hr/> <p>The facility failed to assure residents were not threatened by a staff (Staff I) who carried a utility knife at work and that residents were not spoken to in a dismissive, sharp, provoking and disrespectful manner by staff resulting in residents feeling unsafe and mistreated. This</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NEBO, NC 28761**

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D 338	<p>Continued From page 150</p> <p>failure to uphold residents' rights to a safe environment and to be treated with respect and dignity resulted in serious harm and neglect which constitutes a Type A2 Violation.</p> <hr/> <p>Review of the Plan of Protections submitted by the facility on 9/27/17 and 9/29/17 revealed: -The Assistant Operations Manager (AOM) will meet employee [Staff I] at the facility in the morning (9/28/17) prior to the start of shift. -The AOM will assure [Staff I] has no weapons. -The facility will complete a 24 hour Health Care Personnel Registry report. -The facility will investigate the allegation (of Staff I threatening a resident.) -Residents rights will be re-communicated to all employees to assure all residents' rights are consistently followed. -Additional retraining of residents' rights will be provided by the Long Term Care Ombudsman as soon as the Ombudsman's schedule permits. -The facility's Management will review residents' rights to assure all staff understand importance of the timely reporting to management of any possible violations to residents' rights.</p> <p>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2017.</p>	D 338		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p>	D 358		

Division of Health Service Regulation

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D 358	<p>Continued From page 151</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 4 of 9 (#1, #11, #14, and #15) sampled residents. (Humulin R, Vimpat, clonidine, nitroglycerin, Imdur, Lasix, Risperdal, and melatonin.)</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL2 dated 7/28/17 revealed: -Diagnoses included diabetes type 2, encephalopathy, seizure disorder, hypertension, and bipolar disorder. -Medication orders for Lasix 20mg, 1 and 1/2 tablets (30mg) daily; Humulin R 500u/ml, 18 units with sliding scale twice daily with breakfast and lunch, 17 units with supper, plus sliding scale coverage; Vimpat 100mg, 1 twice daily, clonidine 0.1mg twice daily as needed for blood pressure (BP) greater than 185/100, repeat BP in one hour, if still elevated, call medical doctor, (MD); Nitroglycerin 0.4mg tablets, 1 tablet every 5 minutes for chest pain for 3 doses, and call MD. (Lasix is a medication used to treat hypertension and heart failure, Humulin R is a short acting insulin product used to lower blood sugars at meal times, Vimpat is a medication used to treat certain types of seizure disorders, clonidine is a</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 152</p> <p>medication used to treat hypertension, and nitroglycerin is a medication used to treat chest pain.)</p> <p>-The Humulin R sliding scale read as follows: 150-200= 1 unit, 201-250= 2 units, 251-300= 3 units, 301-350=4 units, 351-400= 6 units, and greater than 400= 8 units and call MD.</p> <p>Review of the Resident Register revealed an admission date of 7/28/17.</p> <p>1. Review of Resident #1's electronic Medication Administration Records (eMARs) for August 2017 revealed:</p> <p>-An entry for Humulin R U-500 Kwikpen per sliding scale for 150-200= 1 unit, 201-250= 2 units, 251-300= 3 units, 301-350=4 units, 351-400= 6 units, and greater than 400= 8 units and call MD.</p> <p>-The sliding scale insulin was scheduled for 7:30am, 12 noon, 5:30pm, and 8pm.</p> <p>-The dose of sliding scale insulin was either omitted or the wrong dose documented as given 11 times out of 124 opportunities.</p> <p>-Example of incorrect doses administered were: 8/6/17 at 7:30am, finger stick blood sugar (FSBS) of 198 and no insulin documented as given, 1 unit required; 8/18/17 at 7:30am, FSBS of 215, 1 unit of insulin documented as given, 2 units required; 8/26/17 at 7:30am, FSBS of 128, 8 units given, and no units required.</p> <p>Record review revealed a subsequent medication order dated 9/21/17 for Humulin R, 19 units with breakfast, and 18 units with lunch and supper.</p> <p>Review of a second subsequent order dated 9/26/17 for Resident #1's Humulin R U-500 Kwikpen insulin revealed:</p> <p>-The breakfast dose of Humulin R was 95 units,</p>	D 358		

Division of Health Service Regulation

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D 358	<p>Continued From page 153</p> <p>with breakfast and lunch doses of 90 units each plus sliding scale coverage.</p> <p>-The sliding scale coverage for breakfast, lunch and supper was as follows: FSBS of 151-200=5 units, 201-250= 10 units, 251-300= 15 units, 301-350= 20 units, 351-400= 30 units, and over 400; 40 units.</p> <p>-The sliding scale coverage for bedtime was as follows: 201-250= 5 units, 251-300= 10 units, 301-350= 15 units, 351-400= 20 units, and over 400= 30 units.</p> <p>Review of Resident #1's eMAR for September 2017 revealed:</p> <p>-The order dated 9/21/17 to change the fixed dose of Humulin R U-500 conc. (vial) to 19 units with breakfast, and 18 units with lunch and supper wasn't entered on the eMAR until 9/27/18 and was discontinued on 9/28/17.</p> <p>-The facility Medication Aides (MAs) documented administering 18 units of Humulin R U-500 with breakfast and lunch at 8am and 12 noon, from 9/1/17 through the noontime administration pass on 9/26/17.</p> <p>-The MAs documented administering the supper Humulin R U-500 dose of 17 units at 5pm from 9/1/17 through 9/25/17.</p> <p>-An entry for sliding scale insulin with Humulin R U-500 conc. (vial) that read, 150-200= 1 unit, 201-250= 2 units, 251-300= 3 units, 301-350=4 units, 351-400= 6 units, and greater than 400= 8 units and call MD, was entered on the MAR on 9/27/17 and discontinued on 9/28/17.</p> <p>-An entry for Humulin R U-500 Kwikpen 500u/ml started on 9/29/17, check FSBS before breakfast and inject subcutaneously per sliding scale; less than 50= treat low blood glucose and give 75 units after breakfast, 51-70= 85 units and immediately eat, 71-150= 95 units, 151-200= 100 units, 201-250= 105 units, 251-300= 110 units,</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 154</p> <p>301-350= 115 units, 351-400= 125 units, and greater than 400= 135 units, with a scheduled administration time of 7:30am.</p> <p>-An entry for Humulin R U-500 Kwikpen 500u/ml started on 9/28/17, check FSBS before lunch and supper and inject subcutaneously per sliding scale; less than 50= treat low blood glucose and give 70 units after lunch and supper, 51-70= 80 units and immediately eat, 71-150= 90 units, 151-200= 95 units, 201-250= 100 units, 251-300= 105 units, 301-350= 110 units, 351-400= 120 units, and greater than 400= 130 units, with scheduled administration times of 12 noon and 5:30pm.</p> <p>-On the morning of 9/29/17 at the 7:30am dose, the MA had documented administering 195 units for a FSBS of 196, when only 100 units were required.</p> <p>Record review of the September 2017 eMAR revealed the new insulin order entered on the eMAR combined the fixed dose of Humulin R with the sliding scale dose at breakfast, lunch, and supper.</p> <p>Interview with Resident #1 on 9/29/17 at 9:10am revealed: -She received 195 units of her regular insulin this morning, and she "had never taken that much insulin before." -When asked how she knew the number of units of insulin she had received, Resident #1 replied, "She (the MA) told me, that's how I knew the dose."</p> <p>Interview with the MA on 9/29/17 at 9:50am revealed: -She had given Resident #1 195 units of Humulin R U-500 this morning from the Kwikpen. -The MA believed the dose on the eMAR was for</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 155</p> <p>the sliding scale only, and the fixed dose of 95 units was to be added to the 100 units noted on the eMAR for a blood sugar of 196.</p> <p>-The MA was not aware the dose of sliding scale insulin and the fixed dose of insulin had been combined on the eMAR entry for Humulin R U-500.</p> <p>-The MA had a paper copy of the original order from 9/26/17 for Resident #1's Humulin R U-500 insulin on top of her med cart, and she was following that order instead of the eMAR.</p> <p>Review of the paper copy of Resident #1's Humulin R U-500 order on top of the med cart revealed the breakfast dose was 95 units plus sliding scale, and the sliding scale dose for a FSBS of 196 was 5 units to equal 100 units.</p> <p>Interview with the facility Administrator, a Registered Nurse, on 9/29/17 at 10:05am revealed she had gone over the new insulin orders with the MAs so they would know how to administer the Humulin R U-500 insulin with the new orders and the new insulin pens.</p> <p>Observation of a recheck of Resident #1's FSBS on 9/29/17 at 10:10am revealed a blood sugar level of 259mg/dl.</p> <p>Interview with the Nurse Practitioner on 10/2/17 at 9:50am revealed:</p> <p>-The facility called after the medication error on 9/29/17 regarding the extra insulin given.</p> <p>-He instructed the facility to check the FSBS every 2 hours and hold all insulin for 8 hours.</p> <p>The facility's failure to administer Resident #1's Humulin R insulin as ordered exposed the resident to increased risk of either a serious hypoglycemic reaction requiring emergency</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 156</p> <p>intervention, or poor long term control over her blood sugar levels leading complications of diabetes including visual impairment, kidney damage, nerve damage, and impaired wound healing.</p> <p>2. Review of a hospital discharge summary for Resident #1 dated 8/25/17 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was seen in the emergency room on 8/24/17 with an initial assessment at 9:24pm. -The resident came in complaining of left sided chest pain radiating down the left arm, shortness of breath and diaphoresis (sweating.) -Her electrocardiogram (EKG) was unchanged from previous EKGs. -Resident #1's cardiac enzymes, (elevated with an actual heart attack), were negative. -The resident's chest pain was relieved with nitroglycerin and she had ambulated without pain or discomfort. -Resident #1 was discharged on a new medication, Imdur 30mg, 1 tablet daily for heart. (Imdur is a long acting medication, similar to nitroglycerin, used to treat coronary artery disease and chest pain.) -Resident #1 was discharged on new medication guidelines to "weigh daily, and take an extra 20mg of Lasix 20mg if 3 pound weight gain in one day, or 5 pounds in 1 week, may also take an extra Lasix if increased shortness of breath or swelling in legs." <p>a. Review of Resident #1's eMARs for August and September 2017 revealed no entry for Imdur 30mg tablets.</p> <p>Observation of Resident #1's medications on hand on 9/28/17 at 9:18am revealed no Imdur tablets in the medication cart available to administer to Resident #1.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 157</p> <p>Interview with the MA at 9:20am on 9/28/17 revealed she had never administered Imdur to Resident #1.</p> <p>Interview with Resident #1 on 9/29/17 at 9:10am revealed: -She was not aware she had any medication to take for chest pain. -She was not aware she had a new medication order for Imdur. -Resident #1 did not have any chest pain since returning from the hospital on 8/25/17.</p> <p>Review of an incident report dated 8/24/17 at 4:45pm completed by the second MA for Resident #1 noted, "Resident was sent to ER due to chest pain,"</p> <p>Interview with the Resident Care Coordinator (RCC) on 9/28/17 at 3:32pm revealed: -She and the Operations Manager (OM) are responsible for checking the accuracy of the MARs. -She was not aware of the new orders on Resident #1's discharge summary from 8/25/17 for Imdur 30mg tablets.</p> <p>Interview with the facility's pharmacy provider on 10/2/17 at 2:35pm revealed: -They had never received the discharge summary for Resident #1 on 8/25/17. -They did not have an order for Imdur 30mg for Resident #1, nor had they ever sent any Imdur for Resident #1.</p> <p>Interview with Resident #1's primary care provider on 9/28/17 at 11:18am revealed he was not aware of any new order for Resident #1 for Imdur.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 158</p> <p>The facility's failure to administer Resident #1's Imdur 30mg tablets exposed the resident to an increased risk of anginal (heart) pain and subsequent heart attack.</p> <p>b. Review of Resident #1's eMARs for August and September 2017 revealed: -No entry for daily weights. -No entry for prn (as needed) Lasix 20mg for weight gain, shortness of breath, or swelling in the legs.</p> <p>Observation of Resident #1's medications on hand on 9/28/17 at 9:18am revealed -No prn Lasix 20mg for Resident #1 to use for shortness of breath, swelling, or weight gain. -A bubble package of Lasix 20mg, 1 and 1/2 tablets daily. -Each bubble contained a whole 20mg tablet as well as a 1/2 tablet to equal 30mg.</p> <p>Interview with the MA at 9:20am on 9/28/17 revealed: -She had never administered any extra prn Lasix to Resident #1 for any reason. -If daily weights were being done, they would be on the treatment record.</p> <p>Review of the treatment record for Resident #1 revealed no entry for daily weights.</p> <p>Interview with Resident #1 on 9/29/17 at 9:10am revealed: -She was never weighed while at the facility. -She was never given any extra fluid pills (Lasix), and had never had any swelling in her legs or shortness of breath.</p> <p>Interview with the Resident Care Coordinator on 9/28/17 at 3:32pm revealed:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 159</p> <p>-She and the Operations Manager (OM) are responsible for checking the accuracy of the MARs.</p> <p>-She was not aware of the new order on Resident #1's discharge summary from 8/25/17 for daily weights with prn Lasix 20mg for weight gain, shortness of breath, or swelling in the lower extremities.</p> <p>Interview with the facility's pharmacy provider on 10/2/17 at 2:35pm revealed:</p> <p>-They had never received the discharge summary for Resident #1 from 8/25/17.</p> <p>-They did not have an order for prn Lasix 20mg with daily weights for Resident #1.</p> <p>-The had never sent any prn Lasix 20mg to administer to Resident #1.</p> <p>Interview with Resident #1's primary care provider on 9/28/17 at 11:18am revealed:</p> <p>-He was not aware of the new orders for Resident #1's prn Lasix with daily weights.</p> <p>-The order for Lasix prn for weight gain would be standard protocol for heart failure.</p> <p>Interview with staff from Resident #1's primary care provider's office (Medical Office Assistants for both Primary care providers and one primary care provider) on 10/2/17 at 9:50am revealed:</p> <p>-The significance of not performing daily weights with prn Lasix would depend on the amount of the weight gain.</p> <p>The facility's failure to obtain daily weights and administer prn Lasix 20mg as ordered exposed Resident #1 to an increased risk of weight gain, shortness of breath, and swelling of the legs. This weight gain, swelling and shortness of breath due to excess retained fluid exposed Resident #1 to risk of congestive heart failure and increased</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 160</p> <p>stress on the heart.</p> <p>c. Review of Resident #1's eMARs for August and September 2017 revealed no documentation Resident #1's nitroglycerin 0.4mg sublingual tablets for chest pain had ever been given.</p> <p>Observation of Resident #1's medications on hand on 9/28/17 at 9:18am revealed a bottle of nitroglycerin 0.4mg sublingual tablets labeled, "place 1 tablet under the tongue as needed for chest pain every 5 minutes for 3 doses, call MD if no relief" with a dispense date of 8/31/17.</p> <p>Interview with the MA at 9:20am on 9/28/17 revealed the old bottle of nitroglycerin tablets prior to 8/31/17 had expired and a new bottle of nitroglycerin was reordered on 8/31/17. -She had never administered nitroglycerin sublingual tablets to Resident #1, but she was not working when the resident went out to the emergency room on 8/24/17.</p> <p>Interview with Resident #1 on 9/29/17 at 9:10am revealed: -She was not given any nitroglycerin tablets on 8/24/17 prior to going to the hospital for chest pain. -It was later in the evening on 8/24/17 when she went out to the ER. -She not aware she had any medication available to administer for chest pain. -Resident #1 did not have any chest pain after returning from the hospital on 8/25/17.</p> <p>Interview with a second MA on 9/29/17 at 10:55am revealed: -She was working on 8/24/17 when Resident #1 had to go to the hospital. -She didn't give Resident #1 any medications</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 161</p> <p>prior to her going to the emergency room.</p> <p>-She was not aware Resident #1 had anything to take for chest pain.</p> <p>-Resident #1 had physical therapy earlier that day in the afternoon, her blood pressure was a little high, and that was why she was sent to the ER, not because of chest pain.</p> <p>-She did not remember what Resident #1's blood pressure was prior to going to the ER.</p> <p>-Resident #1 did not tell her she had any chest pain on the afternoon of 8/24/17.</p> <p>Review of an incident report dated 8/24/17 at 4:45pm for Resident #1 completed by the second MA for Resident #1 noted, "Resident was sent to ER due to chest pain,"</p> <p>Interview with Resident #1 on 9/29/17 at 5:48pm revealed she had to go the ER "about a month ago" for chest pain and told the staff on duty.</p> <p>Interview with staff from Resident #1's primary care provider's office (Medical Office Assistants for both Primary care providers and one primary care provider) on 10/2/17 at 9:50am revealed, they should have given Resident #1 the nitroglycerin, "it may have prevented an ER visit."</p> <p>Failure of the facility staff to administer sublingual nitroglycerin tablets to Resident #1 as ordered on the evening of 8/24/17 exposed the resident to uncontrolled anginal pain, increased risk of a heart attack, and the need for emergency evaluation at the local ER.</p> <p>3. Review of Resident #1's eMARs from August and September 2017 revealed:</p> <p>-Entries for clonidine 0.1mg, 1 tablet by mouth twice daily prn (as needed) for blood pressure (BP) over 185/100, repeat BP in 1 hour, if still</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 162</p> <p>elevated call MD.</p> <p>-Entries for BPs taken at 8am and 8pm.</p> <p>-The BPs for 9/1/17 to 9/30/17 ranged from 110/72 to 186/83, with one BP above 185/100.</p> <p>-The BPs for 8/26/17 through 8/31/17 ranged from 106/72 to 190/90, with one BP above 185/100.</p> <p>-No BPs were documented as taken from 8/1/17 to 8/25/17.</p> <p>-No clonidine 0.1mg was documented as administered on the two days the BPs were above 185/100.</p> <p>-No rechecks of the BPs above 185/100 were documented in the resident's record.</p> <p>Interview with a MA on 9/28/17 at 9:28am revealed she did not recall ever administering clonidine 0.1mg to Resident #1, and if it was not documented on the MAR, it was not given.</p> <p>Review of Resident #1's medications on hand on 9/28/17 at 9:30am revealed:</p> <p>-A bubble pack of clonidine 0.1mg, dispensed on 2/28/17 with 6 tablets remaining out of 30 originally dispensed.</p> <p>-The clonidine was dispensed by a different pharmacy than the facility's pharmacy provider.</p> <p>Interview with the MA at 9:35am on 9/28/17 revealed Resident #1 brought the pack of clonidine 0.1mg with her when she was admitted to the facility.</p> <p>Interview with the RCC on 9/28/17 at 3:32pm revealed:</p> <p>-Both she and the OM were responsible for checking the accuracy of the MARs.</p> <p>-She wasn't sure why the clonidine 0.1mg was not given on the two days BPs were above 185/100.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 163</p> <p>Interview with Resident #1 on 9/29/17 at 9:10am revealed: -She did not recall getting any extra medications for her blood pressure. -She was not aware of what the clonidine 0.1mg tablet looked like, but was aware of the blood pressure parameters to give the clonidine.</p> <p>Interview with staff (Medical Office Assistants for both Primary care providers and one primary care provider) from the primary care provider's office on 10/2/17 at 9:50am revealed not receiving the prn clonidine would have increased Resident #1's risk of continued elevated blood pressure and possibly chest pain.</p> <p>The facility's failure to administer Resident #1's clonidine 0.1mg tablets as ordered by her primary care provider exposed the resident to increased blood pressures and stress on her heart.</p> <p>4. Review of Resident #1's eMARs for August and September 2017 revealed: -An entry for Vimpat 100mg tablets, 1 tablet twice daily with scheduled administration times of 8am and 8pm. -Except for days the resident was noted to be in the hospital, the Vimpat 100mg was documented as administered daily at 8am and 8pm from 8/1/17 through 9/30/17 except for both doses on the 27th and 28th of September 2017. -Those days were initialed and circled as not administered due to "withheld per physician's orders, or "new order, medication not in facility."</p> <p>Review of Resident #1's record revealed no MD order to hold the Vimpat.</p> <p>Observation of Resident #1's medications on</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 164</p> <p>hand on 9/28/17 at 9:18am revealed no Vimpat 100mg tablets available to administer.</p> <p>Interview with Resident #1's primary care provider on 9/28/17 at 11:15am revealed he had just received a request for a refill for Resident #1's Vimpat 100mg and sent a prescription to the pharmacy for refill today.</p> <p>Interview with the facility's pharmacy provider on 9/28/17 at 11:30am revealed: -They had received an order this morning (9/28/17) for Resident #1's Vimpat 100mg and were sending it out today. -The facility had not requested a refill for the Vimpat for Resident #1 until today. -The prior refill for Resident #1's Vimpat was sent on 8/7/17 for a 28 day supply. -They sent a 2 day supply on 9/1/17 of Vimpat to finish out the original script of 60 tablets. -They believed Resident #1 brought some medications with her when she was admitted to the facility, including the Vimpat.</p> <p>Interview with the RCC on 9/28/17 at 3:32pm revealed: -The MA can order medications directly from the computer eMAR screen. -For controlled drugs (like Vimpat), the MAs called the MD when residents are getting low on their supply. -The pharmacy will send a template of the controlled medication refill request, and we fax them to the MD for approval. -Resident #1's primary care provider gave us an order for the Vimpat 100mg until the resident can be seen by the neurologist. -The MAs are supposed to call for refills of controlled drugs when they get to the last row of medication on the bubble pack.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 165</p> <p>Interview with Resident #1 on 9/29/17 at 9:10am revealed: -She was out of her Vimpat for two days. -The Vimpat came in last night and she received a dose this morning. -She did not have any seizure activity when she was out of the Vimpat.</p> <p>Interview with staff (Medical Office Assistants for both Primary care providers and one primary care provider) from the primary care provide's office on 10/2/17 at 9:50am revealed running out of Vimpat could increase her risk of having a seizure.</p> <p>The facility's failure to administer Vimpat to Resident #1 as ordered exposed the resident to an increased risk of seizure activity. The manufacturer of Vimpat warns abruptly stopping the medication can cause uncontrolled seizures, a life threatening medical emergency if not treated promptly.</p> <p>Refer to review of the facility's policy and procedures for medication administration.</p> <p>B. Review of Resident #15's FL2 dated 6/15/17 revealed: -Diagnoses included dementia secondary to Parkinson's, chronic obstructive pulmonary disease (COPD), osteoarthritis and hypothyroidism. -An order for Risperdal 1 mg, by mouth every night (a medication used to treat psychotic symptoms).</p> <p>Review of a subsequent order dated 8/22/17 discontinued the Risperdal 1 mg by mouth every night and started a new order for Risperdal 1 mg, take ½ tablet (0.5 mg) at bedtime.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 166</p> <p>Review of Resident #15's Mental Health Provider's notes dated 9/05/17 revealed: -An order to discontinue Risperdal. -An assessment documented as "d/c Risperdal completely today as it is currently counteracting effects of Sinemet". (Sinemet is a medication used to treat the tremors associated with Parkinson's Disease.)</p> <p>Review of Resident #15's September 2017 electronic Medication Record (eMAR) revealed an entry for risperidone 1 mg, take ½ tablet (0.5 mg) by mouth at bedtime and was documented as administered from 9/01/17 at 8:00pm to 9/25/17 at 8:00pm. (Risperidone is the generic form of Risperdal).</p> <p>Review on 9/27/17 at 4:30pm of Resident #15's medications on hand revealed a prescription bottle for Risperidone 1 mg, take ½ tablet (0.5 mg) by mouth at bedtime, dated 9/01/17 with 3 out of 13 tablets remaining.</p> <p>Interview on 9/26/17 at 1:15pm with Resident #15's Mental Health Provider revealed: -She last saw Resident #15 on 9/05/17 and discontinued the Risperdal because it was counteracting the Sinemet. -She was not aware Resident #15 was still being given the Risperdal. -Resident #15 was 1 of 4 residents that had orders to discontinue a medication and were not implemented by the facility staff from the 9/05/17 visit. -She considered this detrimental to Resident #15's progress and a delay in her treatment. -She expected the staff to administer and discontinue the medications according to her orders.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 167</p> <ul style="list-style-type: none"> -She gave the Medication Aide (MA) a hand written document of all of the medications changes and laboratory orders for all the residents that were seen on each visit. -Later that evening the facility received a fax in the medication room of all orders written that visit. -The orders were not being followed as written and this "was a problem". <p>Interview on 9/26/17 at 1:30pm and 9/27/17 at 11:30am with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -She was not aware of the order to discontinue the Risperdal written for Resident #15 by the Mental Health Provider on 9/05/17. -She was given a hand written paper, by the Mental Health Provider with all of the residents seen today (9/26/17) and the orders that were written during today's visit. -She was told by the Mental Health Provider the visit notes for each resident seen today would come by fax this evening. -She did not tell the Mental Health Provider she did not consider the hand written paper to be physician orders. -All new orders were faxed to the pharmacy once received. -The pharmacy was responsible for entering all new orders in the eMAR to be verified by the MAs before medications could be given. -She was not aware if anyone who checked all of the MARs at the end of the month for accuracy, missed or refused medications. -She was ultimately responsible for making sure all orders were faxed to the pharmacy but MAs could fax any new orders as well. -Any clarifications should be directed to the provider who wrote the order. -Any medication errors were reported to her and to the Operations Manager. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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D 358	<p>Continued From page 168</p> <p>-The MA training was done by the pharmacy nurse and once the MA was checked off then they could give medications.</p> <p>Interview on 9/26/17 at 2:00pm with Resident #15 revealed: -She was not aware the Risperdal was not given as ordered after her last visit on 9/05/17 with the Mental Health Provider. -She received all of her medications. -She did not have issues with behaviors but the tremors were very bad at times. -The staff should follow the doctor's orders and she did not want to be hurt from taking something she was not supposed to take.</p> <p>Interview on 9/26/17 at 2:18pm with the Administrator revealed: -She was not aware of orders that were missed. -She checked the emails received from the providers that contained all new orders and all orders written on 9/05/17 were received by the facility. -She was not sure why the orders were missed and not being followed. -Some prescriptions were sent straight to the pharmacy by escript but all of the 9/05/17 orders were sent by fax. -The RCC was responsible for make sure all orders entered into the eMar were correct and verified in the quick report daily. -She expected the staff to follow all orders.</p> <p>Telephone interview on 9/27/17 at 4:06pm with a Pharmacist at the facility's pharmacy provider revealed: -He was not aware of an order to discontinue Risperdal for Resident #15's dated 9/05/17. -The last 2 times the Risperdal 1 mg (0.5 mg) ½ tablet at night was filled for Resident #15 was on</p>	D 358		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 169</p> <p>8/29/17 for 6 ½ tablets, a 13 day supply and on 9/16/17 for 11 ½ tablets, a 23 day supply. -New orders were either faxed, written on a hard script or by escript (over the computer). -The facility was capable of entering, discontinuing or modifying all orders in the eMAR. -He checked the orders received on 9/05/17 and Resident #15 did not have a discontinue order for the Risperdal. -The pharmacy sent a pharmacy representative every quarter to check the MARs at the facility and the next visit would be in October.</p> <p>Refer to review of the facility's policy and procedures for medication administration.</p> <p>The facility's failure to discontinue the Risperdal completely caused a counteraction to the Sinemet and a delay in Resident #15's progress.</p> <p>C. Review of Resident #14's FL2 dated 8/03/17 revealed: -Diagnoses included, hypertension, seizure disorder, dementia and osteoporosis. -An order for Risperdal, 0.25 mg take ½ (0.125 mg) by mouth two times a day.</p> <p>Review of Resident #14's Mental Health Provider's notes dated 9/05/17 revealed: -An order for Risperdal 0.25 mg take ½ tablet (0.125 mg) nightly. -An assessment documented as "Risperdal was for presumed past behaviors, no behaviors reported".</p> <p>Review of Resident #14's September 2017 electronic Medication Record (eMAR) revealed an entry for Risperidone 0.25 mg, take ½ tablet (0.125 mg) by mouth at two times a day and documented as administered at 8:00am and 8:00</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 170</p> <p>pm from 9/01/17 to 9/25/17 and at 8:00 am on 9/26/17.</p> <p>Review on 9/27/17 at 4:30pm of Resident #14's medications on hand revealed a prescription bottle for Risperidone 0.25 mg, take ½ tablet (0.125 mg) by mouth at two times a day, with a fill date of 9/01/17 with 2 out of 28 tablets left to dispense.</p> <p>Interview on 9/26/17 at 1:15pm with Resident #14's Mental Health Provider revealed:</p> <ul style="list-style-type: none"> -She last saw Resident #14 on 9/05/17 and decreased the order for Risperdal because of "no reported behavioral issues". -She was not aware Resident #14 was still being given the Risperdal twice a day. -Resident #14 was 1 of 4 residents that had orders to discontinue or change a medication were missed from the 9/05/17 visit. -She considered this detrimental to Resident #14's progress and a delay in her treatment. -She expected the staff to give and discontinue the medications according to her orders. -She gave the Medication Aide (MA) a hand written document of all of the medications changes and laboratory orders for all the residents that were seen on each visit. -Later that evening the facility received a fax in the medication room of all orders written that visit. -The orders were not being followed as written and this "was a problem". <p>Interview on 9/26/17 at 1:30pm and 9/27/17 at 11:30am with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -She was not aware of the change in the order written for Resident #14 by the Mental Health Provider on 9/05/17. -She was given a hand written paper, by the 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 171</p> <p>Mental Health Provider with all of the residents seen today (9/26/17) and the orders that were written on today's visit.</p> <ul style="list-style-type: none"> -She was told by the Mental Health Provider the visit notes for each resident seen today will come by fax this evening. -She did not tell the Mental Health Provider she did not consider the hand written paper to be physician orders. -All new orders were faxed to the pharmacy once received. -The pharmacy was responsible for entering all new orders in the eMAR to be verified by the MAs before medications could be given. -She was not aware if anyone would check all of the MARs at the end of the month for accuracy, missed or refused medications. -She was ultimately responsible for making sure all orders were faxed to the pharmacy but MAs could fax any new orders as well. -Any clarifications should be directed to the provider who wrote the order. -Any medication errors were reported to her and to the Operations Manager. -The MA training was done but the pharmacy nurse and once the MA was checked off then they could give medications. <p>Interview on 9/26/17 at 2:18pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was not aware of orders that were missed. -She checked the emails received from the providers that contained all new orders and all orders written on 9/05/17 were received by the facility. -She was not sure why the orders were missed and not being followed. -Some prescriptions were sent straight to the pharmacy by escript but all of the 9/05/17 orders were sent by fax. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 172</p> <ul style="list-style-type: none"> -The RCC was responsible for make sure all orders entered into the eMar were correct and verified in the quick report daily. -She expected the staff to follow all orders. <p>Telephone interview on 9/27/17 at 4:06pm with the Pharmacist revealed:</p> <ul style="list-style-type: none"> -He was aware of the change in the order for Resident #14 dated 9/05/17. -All physician orders entered into the system had to be approved by facility staff before they could be administered. -The new order was "keyed" into the computer but the facility failed to approve the entry and therefore the medication would not show up on the screen as a medication to be adminisitered. -The last 2 times the Risperdal 0.25 mg take ½ tablet (0.125 mg) at twice a day was filled was on 7/25/17 for 20 tablets, a 20 day supply, 8/07/17 for 28 tablets, a 28 day supply, and 9/01/17 for 28 tablet, a 28 day supply. -New orders were faxed, written on a hard script or by escript (over the computer). -The facility was capable of entering, discontinuing or modifying all orders in the eMAR. -The pharmacy sent a pharmacy representative every quarter to check the MARs at the facility and the next visit would be in October. <p>Interview on 10/2/17 at 3:00pm with Resident #14 revealed:</p> <ul style="list-style-type: none"> -She was not aware the Risperdal was changed on 9/05/17 by the Mental Health Provider as ordered. -She received all of her medications. -She did not have issues with behaviors. <p>Refer to review of the facility's policy and procedures for medication administration.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 173</p> <p>The facility's failure to reduce the dose of the Risperdal caused Resident #14 to be administered unnecessary medication and could pose a delay in Resident #14's progress.</p> <p>D. Review of Resident #11's FL2 dated 4/20/17 revealed: -Diagnoses included depression, hypertension, and a history of burns. -A physician's order for klonopin 1 mg at 8am and 2pm, klonopin 2 mg at bedtime and melatonin 5 mg take 2 tablets (10 mg) at bedtime.</p> <p>Review of a subsequent order dated 9/05/17 to continue the klonopin 1 mg at 8am and 2pm, klonopin 2 mg at bedtime and to discontinue the melatonin 5 mg take 2 tablets (10 mg) at bedtime.</p> <p>Review of Resident #11's Mental Health Provider's notes dated 9/05/17 revealed: -An order to discontinue the melatonin 5 mg take 2 tablets (10 mg) at bedtime and continue the klonopin 1 mg at 8am and 2pm, klonopin 2 mg at bedtime . -An assessment documented Resident #11 was already taking Remeron for insomnia.</p> <p>Review of Resident #11's September 2017 electronic Medication Record (eMAR) revealed an entry for melatonin 5 mg take 2 tablets (10 mg) at bedtime and documented as given at 8:00pm from 9/01/17 to 9/25/17.</p> <p>Review on 9/27/17 at 4:30pm of Resident #11's medications on hand revealed a prescription bottle for melatonin 5 mg take 2 tablets (10 mg) at bedtime, dated 9/1/17 with 4 out of 56 tablets left to dispense.</p> <p>Interview on 9/26/17 at 1:15pm with Resident</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 174</p> <p>#11's Mental Health Provider revealed: -She last saw Resident #11 on 9/05/17 and discontinued the melatonin because he was already taking remeron for insomnia. -She was not aware Resident #11 was still being given the melatonin. -Resident #11 was 1 of 4 residents that had orders to discontinue or change a medication were missed from the 9/05/17 visit. -She considered this detrimental to Resident #11's progress and a delay in her treatment. -She expected the staff to give and discontinue the medications according to her orders. -She gave the Medication Aide (MA) a hand written document of all of the changes for medications and labs for all the residents that were seen on each visit. -Later that evening the facility received a fax in the medication room of all orders written that visit. -The orders were not being followed as written and "was a problem".</p> <p>Interview on 9/26/17 at 1:30pm and 9/27/17 at 11:30am with the Resident Care Coordinator (RCC) revealed: -She was not aware of the discontinue order written for Resident #11 by the Mental Health Provider on 9/05/17. -She was given a hand written paper, by the Mental Health Provider with all of the residents seen today (9/26/17) and the orders that were written on today's visit. She was told by the Mental Health Provider the full print out of the visit for each resident seen today will come by fax this evening. -She did not tell the Mental Health Provider she did not consider the hand written paper would not be accepted. -All new orders were faxed to the pharmacy once received.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 175</p> <ul style="list-style-type: none"> -The pharmacy was responsible for entering all new orders in the eMAR to be verified by the MAs before medications can be given. -She was not aware of anyone who would check all of the MARs at the end of the month for accuracy, missed or refused medications. -She was ultimately responsible for making sure all orders were faxed to the pharmacy but MAs could fax any new orders as well. -Any clarifications should be directed to the provider who wrote the order. -Any medication errors were reported to her and to the Operations Manager. -The MA training was done but the pharmacy nurse and once the MA was checked off then they could give medications. <p>Interview on 9/28/17 at 12:15pm with Resident #11 revealed:</p> <ul style="list-style-type: none"> -He was not aware the melatonin was not to be given after his last visit on 9/05/17 with the Mental Health Provider as ordered. -He received all of his medications. -He did feel too sleepy most mornings. -The staff should follow the doctor's orders. <p>Interview on 9/26/17 at 2:18pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was not aware of orders that were missed. -She checked the emails received from the providers that contained all new orders and all orders written on 9/05/17 were received by the facility. -She was not sure why the orders were missed and not being followed. -Some prescriptions were sent straight to the pharmacy by escript but all of the 9/05/17 orders were sent by fax. -The RCC was responsible for make sure all orders entered into the eMar were correct and 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 176</p> <p>verified in the quick report daily. -She expected the staff to follow all orders.</p> <p>Telephone interview on 9/27/17 at 4:06pm with the Pharmacist revealed: -He was not aware of a discontinue order for Resident #11 dated 9/05/17. -The last 2 times the melatonin 5 mg take 2 tablets (10 mg) at bedtime was 8/07/17 for 56 tablets, a 28 day supply and 9/01/17 for 56 tablets, a 28 day supply. -New orders were faxed, written on a hard script or by escript (over the computer). -The facility was capable of entering, discontinuing or modifying all orders in the eMAR. -He checked the orders received on 9/05/17 and Resident #11 did not have a discontinue order for the Risperdal. -The pharmacy sent a pharmacy representative every quarter to check the MARs at the facility and the next visit would be in October.</p> <p>Refer to review of the facility's policy and procedures for medication administration.</p> <p>The facility's failure to discontinue the melatonin delayed Resident #11 progress by increasing the possibility of becoming over sedated because he was already taking remeron for insomnia.</p> <hr/> <p>Review of the facility's policy and procedures for medication administration revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Documentation will be provided for each dose of medication by the medication aide who prepares the medications for administration.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 177</p> <ul style="list-style-type: none"> -The MAR will include the following information: omissions and refusals of medications and the reason for omissions will be documented on the MAR. -The MAR will be updated and changed when medication or treatment order from the prescribing practitioner changes. -Documentation on the MAR will be the prevailing record for medication administration when the label on the medication container has not been relabeled by the pharmacy. -In the even of a medication error and adverse reaction to medications, facility staff will: Notify physician, their supervisor, document any orders received from and the physician and actions taken by the facility to comply with the order. -Charting will identify if documentation errors, unavailability of medications, or resident's refusal of medication may have led to the medication error. <hr/> <p>The facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 4 of 9 (#1, #11, #14, and #15) sampled residents. This failure exposed Resident #1 to a risk of a serious hypoglycemic reaction and complications of uncontrolled diabetes, worsening of lower extremity swelling and shortness of breath, chest pain related to coronary artery disease and an unnecessary trip to the emergency room, an increased risk a seizure activity, and elevated blood pressures. This failure exposed Resident #11 and #15 to a delay in treatment, Resident # 11, #14 and #15 an increase in sedation, and Resident #15 counteraction with Sinemet. Therefore these failures exposed residents to substantial risk that death or serious physical harm will occur and constitute a Type A2 Violation.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D 358	<p>Continued From page 178</p> <hr/> <p>Review of a Plan of Protection provided by the facility on 9/29/17 revealed: -Orders will be corrected immediately. -Audits will be begin to make sure no other orders are missed and they are received by the pharmacy in a timely manner. -PRN (as needed) medications will be given as indicted. -All outside physician's orders will be implemented. -Orders will be reviewed tomorrow from the most recent visit. -Order log will be reviewed no less than weekly by the RCC. -This will be for all new orders written the the physician. -Additional training will be provided for MA over the next 2 weeks that will include ordering of medications.</p> <p>DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2017.</p>	D 358		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D912	<p>Continued From page 179</p> <p>interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the areas of medication administration, health care implementation, and implementation.</p> <p>The findings are:</p> <p>A. Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 1 of 6 sampled residents with physician's orders for wound care and dressing changes (Resident #15). [Refer to Tag 276 10A NCAC 13F .0902(c) Health Care (Type B Violation.)]</p> <p>B. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 4 of 9 (#1, #11, #14, and #15) sampled residents. (Humulin R, Vimpat, clonidine, nitroglycerin, Imdur, Lasix, Risperdal, and melatonin.) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation.)]</p> <p>C. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, resident assessments, supervision, personal care, staffing, nutrition and food service, housekeeping and furnishings, and residents' rights. [Refer to Tag 980 G.S. 131D-25 Implementation (Type A2 Violation).]</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from mental and physical abuse and neglect in the areas of personal care and supervision, personal care and staffing, and resident rights.</p> <p>The findings are:</p> <p>A. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of residents on 6 of 21 shifts which were short aide hours according to the facility census and where staff worked as transportation, performed laundry duties and assisted in the dining room as dietary aides resulting in staff not providing every two hour incontinence care and safety checks, bathing and supervision for residents with known aggressive, wandering and self-harming behaviors. [Refer to Tag 188 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation.)]</p> <p>B. Based on observations, interviews and record reviews, the facility failed to assure the primary job responsibility of the Personal Care Aides (PCAs) was to provide direct personal care and supervision as evidenced by PCAs assigned dual roles such as transportation, laundry and dietary aide resulting in a lack of incontinence care, bathing and supervision of residents with known aggressive, wandering and self-harming</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D914	<p>Continued From page 181</p> <p>behaviors. [Refer to Tag 189 10A NCAC 13F .0604(e)(2)(A-E) Personal Care and Other Staffing (Type B Violation.)]</p> <p>C. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance such as incontinence care, bathing and dressing for 3 of 5 sampled residents (#2, #15 and #17) resulting in Resident #17 becoming accustomed to lying on a urine saturated bed sheet and incontinence pad; Resident #2 not being bathed for the month of September 2017; and Resident #15 having to find staff to ask for assistance with daily bathing and dressing needs. [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation.)]</p> <p>D. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 5 of 9 sampled residents (#5, #6, #9, #16, and #18), related to drinking hand sanitizer and mouthwash, eating out of the trash, fighting, smoking in the building, wandering into other resident's rooms and stealing, and throwing temper tantrums, in accordance with the resident's assessed needs and current symptoms. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation.)]</p> <p>E. Based on observations, interviews and record reviews, the facility failed to assure residents were not threatened by a staff (Staff I) who carried a utility knife at work; verbally threatened by a staff (Staff E); and that residents were not spoken to in a dismissive, sharp, provoking and disrespectful manner by staff. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation.)]</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>G.S. § 131D-25 Implementation</p> <p>G.S. 131D-25 Implementation</p> <p>Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, resident assessments, supervision, personal care, staffing, nutrition and food service, housekeeping and furnishings, and residents' rights.</p> <p>The findings are:</p> <p>Interview with the facility Administrator on 10/2/17 at 12:55pm revealed: -She was in the facility 60 hours a week. -She assisted the Operations Manager with decisions about the facility operation. -She audits records. -"I handle the firings, the Operations Manager and the Resident Care Coordinator monitor staff."</p> <p>Confidential interview with a resident revealed the Operations Manager (OM) and Assistant</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 183</p> <p>Operations Manager (AOM) were nice people, but they rarely came out of the office to see what went on in the facility.</p> <p>Confidential interview with a staff member revealed everything was not getting done the way it was supposed to be because the management staff needed to get out of the office and see what was really happening in the facility.</p> <p>A. Based on observations, interviews and record reviews, the facility failed to assure the walls, floors and ceilings in 22 residents' rooms and bathrooms (rooms #101, #103, #105, #107, #200, #201, #203, #205, #207, #210, #403, #405, #407 shared bathroom, the common bathrooms (100, 200 and 300 hall even common-bath, front and back hall), the dining room and all hallways, and the common living room on the 400 hall, were kept clean and in good repair. [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings.]</p> <p>B. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of residents on 6 of 21 shifts which were short aide hours according to the facility census and where staff worked as transportation, performed laundry duties and assisted in the dining room as dietary aides resulting in staff not providing every two hour incontinence care and safety checks, bathing and supervision for residents with known aggressive, wandering and self-harming behaviors. [Refer to Tag 188 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation.)]</p> <p>C. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance such as incontinence care, bathing</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 184</p> <p>and dressing for 3 of 5 sampled residents (#2, #15 and #17) resulting in Resident #17 becoming accustomed to lying on a urine saturated bed sheet and incontinence pad; Resident #2 not being bathed for the month of September 2017; and Resident #15 having to find staff to ask for assistance with daily bathing and dressing needs. [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation.)]</p> <p>D. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 5 of 9 sampled residents (#5, #6, #9, #16, and #18), related to drinking hand sanitizer and mouthwash, eating out of the trash, fighting, smoking in the building, wandering into other resident's rooms and stealing, and throwing temper tantrums, in accordance with the resident's assessed needs and current symptoms. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation.)]</p> <p>E. Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 1 of 6 sampled residents with physician's orders for wound care and dressing changes (Resident #15). [Refer to Tag 276 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation.)]</p> <p>F. Based on observations, record reviews, and interviews, the facility failed to assure residents received a place setting consisting of a knife, fork and spoon for all residents residing in the facility. [Refer to Tag 287 10A NCAC 13F .0904(b)(2) Nutrition and Food Service.]</p> <p>G. Based on observations, interviews and record</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 185</p> <p>reviews, the facility failed to provide assistance with meals that promoted dignity and respect for 1 of 1 sampled residents (#15) with a diagnosis of dementia and Parkinson, who needed assistance in the dining room during two meal observations. [Refer to Tag 312 10A NCAC 13F .0904(f)(2) Nutrition and Food Service.]</p> <p>H. Based on observations, interviews and record reviews, the facility failed to assure residents were not threatened by a staff (Staff I) who carried a utility knife at work; verbally threatened by a staff (Staff E); and that residents were not spoken to in a dismissive, sharp, provoking and disrespectful manner by staff. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation.)]</p> <p>I. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 4 of 9 (#1, #11, #14, and #15) sampled residents. (Humulin R, Vimpat, clonidine, nitroglycerin, Imdur, Lasix, Risperdal, and melatonin.) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation.)]</p> <p>J. Based on observations, interviews and record reviews, the facility failed to assure there were no chronic urine, feces, body and mildew odors in three resident rooms (#105, #107 and #207) and in the 100 and 200 hall hallways. [Refer to Tag 075 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings.]</p> <p>K. Based on observations, interviews and record reviews, the facility failed to assure the environment in 9 resident rooms and common bathrooms on the 100, 200 and 400 hall were</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 186</p> <p>kept in a clean and orderly manner and free of hazards such as feces on shared toilets, overflowing closets and leaking showers and urinals. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings.]</p> <p>L. Based on observations, interviews, and record reviews, the facility failed to assure sufficient staff for safe and sanitary food service including providing beverages, condiments, and additional servings; serving food in an unrushed fashion; monitoring and assisting residents for safe meal consumption. [Refer to Tag 286 10A NCAC 13F .0904(b)(1) Nutrition and Food Service.]</p> <p>M. Based on observations, interviews and record reviews, the facility failed to assure the kitchen and dining room were kept clean, orderly and free from contamination as evidenced by heavy dirt, dust and food particles on the floors in the dining room and pantry, dead flies on the window sills in the dining room and drip marks, scuff marks and finger print on the doors to the kitchen and dining room. [Refer to Tag 282 10A NCAC 13F .0904(a) (1) Nutrition and Food Service.]</p> <p>N. Based on observations, interviews and record reviews, the facility failed to assure the primary job responsibility of the Personal Care Aides (PCAs) was to provide direct personal care and supervision as evidenced by PCAs assigned dual roles such as transportation, laundry and dietary aide resulting in a lack of incontinence care, bathing and supervision of residents with known aggressive, wandering and self-harming behaviors. [Refer to Tag 189 10A NCAC 13F .0604(e)(2)(A-E) Personal Care and Other Staffing (Type B Violation.)]</p> <p>O. Based on observations, interviews, and record</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D980	<p>Continued From page 187</p> <p>reviews, the facility failed to assure an assessment for 2 of 2 residents (#4, #7) was reviewed with significant changes, including deterioration in three activities of daily living in the areas of bathing, grooming, and dressing were completed within 10 days of the change in the residents' condition. [Refer to Tag 255 10A NCAC 13F .0801(c)(1) Resident Assessment.]</p> <hr/> <p>The Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, resident assessments, supervision, personal care, staffing, nutrition and food service, housekeeping and furnishings, and residents' rights. These failures exposed residents to a variety of problems including serious medication errors, fights, smoking in the facility, having personal items stolen from their rooms, exposure to serious communicable diseases, neglect related to personal care and supervision and feeding assistance, abuse and threats by staff, an unclean environment, and inadequate management of nutrition and food service. Therefore these failures exposed residents to substantial risk that death or serious physical harm, abuse, or neglect will occur and constitute a Type A2 Violation.</p> <hr/> <p>Review of the Plan of Protection provided by the facility on 9/29/17 revealed: -Facility management will assure all rules and regulations are followed. -Facility Administrators will review staff</p>	D980		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2017
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D980	Continued From page 188 implementation of all rules and regulations and communicate to staff any needed improvements. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2017.	D980		