STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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CEDARBROOK RESIDENTIAL CENTER	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 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation survey on July 28-29, 2022, August 2-5, 2022, and August 8-11, 2022, with an exit conference via telephone call on August 12, 2022. The survey involved several complaints, including #NC00191321 and #NC00191894, and re-opened a previous complaint (#NC00190372). This complaint investigation includes findings of non-compliance that were not previously identified during the July 20, 2022 annual survey.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 9 sampled residents (Resident #2) after the resident, who had a history of aggressive behavior, exhibited an escalation in behavior, and was known to be using illicit drugs, verbalized a threat to harm someone so he could leave the facility and go to jail. The findings are: Review of Resident #2's current FL2 dated	D 270		

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D 270	Continued From page 1 12/02/21 revealed diagnoses included [redacted] Review of Resident #2's Mental Health Nurse Practitioner (NP) orders dated 04/12/22 revealed additional diagnoses of [redacted] Review of Resident #2's Care Plan dated 05/19/22 revealed: -[redacted] Review of local law enforcement 911 call log dated 03/31/22 revealed: -There was a call received at 6:49pm in reference to disturbance. -Resident #2 was listed as very combative. -The incident involved a physical disturbance. -Facility staff were trying to keep all other patients and staff away from Resident #2. Review of Resident #2's admission History and Physical [redacted] dated 04/01/22 revealed:	D 270		

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D 270	Continued From page 2 -[redacted] Review of Resident #2's Discharge Summary from an [redacted] dated 04/08/22 revealed: -[redacted].	D 270		

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D 270	Continued From page 3 Review of Resident #2's Resident Life Coordinator (RLC) Daily Notes dated 04/01/22 revealed [redacted] Review of Resident #2's RLC Daily Notes dated 04/11/22 revealed: -Resident #2 was agitated, delusional, and upset that he was not prescribed the same meds [redacted] -Resident #2 stated he was going to his room to cry. -RLC spoke with the Mental Health Nurse Practitioner (NP) about Resident #2's [redacted] Review of Resident #2's RLC Daily Notes dated 04/12/22 revealed: -Resident was stabbed with a small pocketknife by another resident. -Emergency Medical Services (EMS) evaluated, transported to Emergency Department (ED) and returned to facility. -He was delusional, grandiose, mood labile. -Admitted to using synthetic marijuana, unwilling to discontinue, unwilling to discuss possible medication interaction or [redacted] Review of Resident #2's RLC Daily Notes dated 04/13/22 revealed: [redacted].	D 270		

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D 270	Continued From page 4 -Stated he needed to use Delta 8 (synthetic marijuana) to unwind and relax. -There was no documentation of any staff interventions or increased supervision to address Resident #2's assessed needs and symptoms. Review of Resident #2's RLC Daily Notes dated 05/02/22 revealed resident appeared very delusional, mildly agitated, wanted to gain independent housing and was unable to be redirected. Review of Resident #2's charting notes for 05/03/22 at 7:31pm revealed: -The resident had a lot of delusions lately, stating he was a ranking government official in the world. -The resident got agitated when speaking of facility and stated he had more money than anyone in the world. [redacted] -The resident's guardian and mental health/primary care providers were aware and would continue to work with resident. -There was no documentation of any staff interventions or increased supervision to address Resident #2's assessed needs and symptoms. Review of local law enforcement 911 call log dated 05/04/22 revealed: -At 3:34pm, a caller stated, "the doctor is not giving him medications for his body". -Resident #2 was the reported caller. Review of Resident #2's RLC Daily Notes dated 05/31/22 revealed: -Resident #2 was mildly agitated and wanted to make real money. -Resident #2 later became agitated and wanted to get paid for work around the facility.	D 270		

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D 270	Continued From page 5 -RLC informed the resident of the facility's policy on work completed by residents. -Resident #2 experienced increased agitation. -There was no documentation of any staff interventions or increased supervision to address Resident #2's assessed needs and symptoms. Review of Resident #2's MHRN visit note dated 06/03/22 revealed: -[redacted] Review of Resident #2's RLC Daily Notes dated 06/03/22 revealed: [redacted]. -There was no documentation of any staff interventions or increased supervision to address Resident #2's assessed needs and symptoms. Review of Resident #2's MHRN visit note dated 06/06/22 revealed: [redacted]. Review of Resident #2's RLC Daily Notes dated 06/06/22 revealed:	D 270		

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D 270	Continued From page 6 -The OM spoke with the resident's guardian who stated Resident #2 called her today and seemed agitated. -The OM stated Resident #2 was upset about his finances. -The RLC spoke with Resident #2 and encouraged PRN (as needed) medication if he felt agitated. Review of Resident #2's Mental Health Licensed Clinical Social Worker (LCSW) note dated 06/09/22 revealed: -[redacted] Review of Resident #2's Mental Health NP visit note dated 06/27/22 revealed: [redacted]	D 270		

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D 270	Continued From page 7 Review of Resident #2's MHRN visit note dated 06/29/22 revealed [redacted]. Review of Resident #2's Mental Health LCSW visit note dated 07/01/22 revealed Resident #2 [redacted] Telephone interview with a personal care aide (PCA) on 08/05/22 at 1:05pm revealed: -On 07/05/22 he was in the medication room with a Medication Aide (MA), MA supervisor, and the MHRN when Resident #2 stated "he was going to have to hurt someone to get out of there so he could go back to jail". -He told Resident #2 that Resident #2 didn't want to do that. -He did not report Resident #2's statement regarding potential harm to someone to any additional staff. Telephone interview with a MA on 08/05/22 at 1:49pm revealed: -Resident #2 had delusions and [redacted] -On 07/05/22 she was in the medication room with a PCA, the MA supervisor, and a MHRN when Resident #2 stated he was going to have to hurt someone to get out of there so he could go get back to jail. -She stated the MHRN did not respond to Resident #2 regarding his statement of potential harm to someone. -She or the MA supervisor should have initiated 15-minute checks on Resident #2 but did not. -She initially thought she had reported this to the Operations Manager (OM) but later confirmed she had not.	D 270		

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D 270	Continued From page 8 -She or the MA supervisor should have reported this to the OM or the Resident Care Coordinator (RCC). -She or the MA supervisor should have called mental health crisis and notified his MHP. -She did not report Resident #2's statement regarding potential harm to someone to any additional staff. -She did not fill out an Accident/Incident report regarding Resident #2's statement of potential harm to others on 07/05/22. Telephone interview with MA Supervisor on 08/05/22 at 10:52am revealed: -On 07/05/22, she was in the medication room with a PCA, a MA and a MHRN when Resident #2 stated he was going to hurt someone to get out of there so he could go get back to jail. -The MHRN did not respond to Resident #2 regarding his statement of potential harm to someone but did write something down. -She expected the MHRN to report Resident #2's threats to his MHP. -She could not complete Involuntary Commitment (IVC) paperwork and expected the MHRN to complete it. -She stated MA's cannot complete IVC paperwork. -She should have initiated 15-minute checks on Resident #2 but did not. -She should have reported this to the OM or RCC. -She did not report Resident #2's statement until after the Resident Care Coordinator (RCC) returned to work after being out on leave. -She should have called mental health crisis and notified his MHP. -She did not fill out an Accident/Incident report regarding Resident #2's comment.	D 270		

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D 270	Continued From page 9 Interview with the RCC on 08/03/22 at 2:30pm revealed: -She was notified by the MA Supervisor on 07/11/22, when she returned to work, of Resident #2's statement regarding potential harm to others made on 07/05/22. -Staff should have initiated 15-minute checks on Resident #2 and the MA Supervisor should have reported this to mental health crisis. -She did not know if anyone had notified the OM, Primary Care Provider (PCP) or MHP. -Staff should have notified the PCP or MHP. -She did not notify anyone when Resident #2's statement was reported to her. Interview with OM on 08/03/22 at 3:28pm revealed: -She was not aware that Resident #2 had made a statement regarding potential harm to others. -Staff should have initiated 15-minute checks on Resident #2 -Staff should have immediately notified the MHP and mental health crisis. -Staff should have notified Resident #2's PCP or MHP regarding Resident #2's comments. Review of Resident #2's record revealed: -There was no documentation of the PCP, MHP, and mental health crisis being notified of Resident #2's statement on 07/05/22. -There was no documentation of increased supervision after Resident #2 made the statement on 07/05/22 regarding potential harm to others. Review of Resident #2's MHRN visit note dated 07/05/22 revealed: - [redacted]	D 270		

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D 270	Continued From page 10 [redacted]. Review of Resident #2's Mental Health LCSW visit note dated 07/07/22 revealed: - [redacted]	D 270		

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D 270	Continued From page 11	D 270		

-[redacted]

Review of Resident #2's MHRN visit note dated 07/09/22 revealed [redacted].

Review of Resident #2's Accident/Injury Report dated 07/09/22 at 9:11pm revealed:
-There was documentation dated 07/10/22 from the OM, observed camera footage on 07/10/22 where Resident #2 was observed becoming very aggressive, leaving another resident laying on the 100 porch as he walked away.
-The Administrator was notified and then law enforcement, no time listed.
-While waiting on response from law enforcement Resident #2 was monitored closely via live camera feed only, with no in person/one on one supervision.
-At approximately 2:30pm Resident #2 was taken into custody by local law enforcement.
-Immediate discharge was sent to Resident #2's guardian via email which had been requested by phone.

Review of the "100 Entrance" video footage from 07/09/22 at 8:56pm until 07/10/22 at 5:25am without audio revealed:
-At 8:56pm, video revealed Resident #2 approached a drink machine/porch area coming from the right side of the building (when facing the building).
-Resident #2 stood in front of the drink machine.
-At 9:02pm, a female resident walked from the front of the building to the drink machine/porch

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D 270	Continued From page 12	D 270		

area carrying a chair.
-Resident #2 picked up nearby chair and held the chair up in the air and he appeared to be speaking to the female resident.
-The female resident placed her chair down to the left of the drink machine and sat in the chair.
-It did not appear the female resident was engaging in conversation with Resident #2.
-Resident #2 looked agitated, appeared to be yelling at the female resident as he dropped his chair and then kicked the chair.
-Resident #2 started walking backwards, appeared to be yelling and pointing at the chair he just kicked.
-At 9:04pm, Resident #2 picked up the chair he just dropped and kicked and placed it upright to the right of the drink machine.
-Resident #2 stood with his arms crossed in front of his torso.
-At 9:08, Resident #2 appeared to be agitated and pointed his right index finger at the female resident.
-Resident #2 placed his left hand in the pocket of his shorts and displayed a wide stance.
-At 9:09pm, the video went from color to black and white (night vision).
-At 9:09pm, the female resident got up from her chair and walked to the front of the building, out of camera view while Resident #2 stood in front of the drink machine.
-At 9:13pm, the female resident returned to the drink machine/porch area and sat down on the same chair.
-At 9:16pm, the female resident got up from her chair and stood in front of the drink machine for a moment and then sat back down.

[redacted]

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D 270	Continued From page 13	D 270		

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D 270	Continued From page 14	D 270		

[redacted]

Telephone interview with Resident #2's Mental Health NP on 08/05/22 at 2:24pm revealed:

[redacted].

Telephone interview with Resident #2's PCP on 08/02/22 at 1:11pm, 08/04/22 at 3:14pm and 08/09/22 at 1:23pm revealed:

-[redacted]

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D 270	Continued From page 15 [redacted] Interview with a local law enforcement deputy on 07/28/22 at 5:15pm revealed: -He was the responding officer on 07/10/22 where Resident #2 assaulted a female resident. -After he viewed the facility video footage of Resident #2 assaulting a female resident, he immediately called a detective. [redacted] Interview with a local law enforcement detective on 07/29/22 at 9:31am revealed: -She was the responding detective on 07/10/22 where Resident #2 assaulted a female resident after receiving a call from deputy. -She viewed the facility video footage of Resident #2 assaulting a female resident. -She asked Resident #2 why he assaulted the	D 270		

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D 270	Continued From page 16	D 270		

female resident and he stated the facility was drugging him and because the female resident had asked him to kill her.
-Blood was found on the shoes and shorts Resident #2 was wearing in the video during the assault.
-Resident #2 stated that prison was going to be better than being at the facility.
-She asked Resident #2 if he and the female resident he assaulted were friends and Resident #2 stated he didn't want to say anything else that would jeopardize his competency hearing.
-Resident #2 had a criminal history which included, driving under the influence (DUI), marijuana possession, assault and battery, assault on a government official, resisting arrest and communicating threats.
-She remembered an altercation between Resident #2 and a staff member at the facility in the past.

Review of a female resident's EMS Patient Care Record dated 07/10/22 revealed:

[redacted]

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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 270	Continued From page 17	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 270	Continued From page 18	D 270		

[redacted]

Review of the female resident's EMS assessment performed on 07/10/22 at 5:48am and 5:59am revealed:

[redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 270	Continued From page 19	D 270		

[redacted]

Review of the female resident's ED records dated 07/10/22 revealed:

-[redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 270	Continued From page 20 [redacted] Review of the female resident's Trauma Progress Note Impression and Plan dated 07/25/22 revealed: [redacted] Review of the female resident's hospital discharge summary dated 07/28/22 revealed: [redacted]	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 270	Continued From page 21 [redacted]. Telephone interview with a Registered Nurse (RN) at a SNF on 08/05/22 at 2:00pm revealed: -[redacted] Review of the female resident's SNF nursing progress note dated 07/29/22 at 2:18am and 6:28am revealed: [redacted] Telephone interview with the RLC on 08/03/22 at 1:14pm revealed his job duties included keeping the residents happy, retention of residents, keep down unacceptable resident behaviors, keep staff happy, and to help keep residents safe. Interview with the Resident Life Coordinator (RLC) on 08/04/22 at 10:00am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 270	Continued From page 22	D 270		

-Resident #2 had consistent behaviors but could be erratic at times.
-Resident #2 had good days and then there were times he was very angry and delusional about who he was.
-The facility suspected drug abuse and Resident #2 was smoking Delta-8 daily.
-Resident #2 was intelligent and knew what he wanted.
-Resident #2 had become aggressive with a female staff a couple of months ago.
-The aggressive behavior towards female staff was addressed with the resident.
-Resident #2 never verbalized any threats to harm others to the RLC.

Interview with the Operations Manager (OM) on 07/29/22 at 4:58pm revealed:
-There was no reason to increase supervision for Resident #2 prior to the physical assault of a female resident on 07/09/22.
-The facility did not have a written policy on increased supervision related to behaviors.
-The facility's policy was to implement 15-minute checks for a 72-hour period after an incident occurred and the involved resident remained in the facility.

Telephone interview with the OM on 08/08/22 at 3:10pm revealed:
-If staff overheard a verbal threat made by a resident orif a resident had a change in behavior she expected the MA Supervisor to call mental health crisis.
-She expected staff to increase supervision of that resident until mental health crisis had completed their evaluation and made recommendations.
-She was not aware that Resident #2 had made a statement regarding potential harm to other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 270	Continued From page 23	D 270		

people on 07/05/22.
-If she had been notified by staff of the verbal threat made by Resident #2 on 07/05/22, and they had not called mental health crisis, she would have instructed them to do so.
-She did not expect the MA Supervisor to notify her if they called mental health crisis.
-There was no written policy and procedure regarding increasing supervision of a resident involved in an assault, but the facility would usually implement 15 minute checks on the resident.
-The MA supervisor could make the determination if an increase in supervision was needed.
-Sometimes staff would ask the OM if an increase in supervision was needed based on what had occurred.

Interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm revealed:
-She was responsible for the overall management of the facility.
-The Administrator and the Owner were both on vacation and she would be our primary contact person.
-She had worked in the facility since 2007.

Interview with the OM on 08/02/22 at 10:11am revealed the Administrator and the owner remained on vacation this week and she would continue to be our primary contact person.

Interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am revealed:
-The RLC would be left in charge during any of her absence from the facility.
-The Administrator remained unavailable.

_____
The facility failed to ensure supervision was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 270	Continued From page 24 increased for Resident #2, diagnosed with [redacted] after he exhibited escalating behaviors, was known to be using illicit drugs, and made a verbal threat to harm someone so he could leave the facility and go to jail. Resident #2 brutally attacked a female resident as she sat outside in a chair by punching and stomping on her in the face and head and choking her. The failure to increase supervision resulted in substantial risk of serious physical harm to other residents and constitutes a Type A2 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on August 12, 2022. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION WILL NOT EXCEED SEPTEMBER 11, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 6 sampled residents (Residents #10 and #2) related to the facility's failure to notify the primary care provider and make a referral to appropriate mental health services after an allegation of a	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 25	D 273		

sexual assault (Resident #10), and failure to notify the primary care provider, mental health provider, and mental health crisis provider of a verbal threat made by a resident to harm someone so he could leave the facility and go to jail (Resident #2).

The findings are:

1. Review of Resident #10's FL2 dated 04/05/22 revealed:
-Diagnoses included intellectual disability, anxiety, depression, and conduct disorder and outburst.
-The resident was ambulatory.

Review of Resident #10's Resident Register revealed:
-There was an admission date of 04/21/22.
-The resident had a guardian of the person.

Review of Resident #10's Care Plan dated 05/02/22 revealed:
-The resident was oriented with adequate memory.
-The resident required limited assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #9's current FL2 dated 02/17/22 revealed diagnoses included a history of head trauma, traumatic brain injury, and schizoaffective disorder.

Review of Resident #9's physician's orders dated 03/28/22 revealed an additional diagnosis of schizophrenia.

Review of Resident #9's Care Plan dated 02/03/22 revealed:
-Resident #9 had a history of mental illness and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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D 273	Continued From page 26	D 273		

was receiving medications for mental illness/behavior.
-There was no documentation of behavioral issues.
-Resident #9 was oriented with an adequate memory and ambulated independently.

Telephone interview with Resident #10 on 08/03/22 at 10:42am revealed:
-She was raped when she lived at the facility.
-She was in her room using the bathroom.
-She heard a knock on the bathroom door.
-Resident #9 came into the bathroom and started kissing her.
-Resident #9 hit her head against the wall.
-He laid on top of her on her bed.
-He tried to take her pants off.
-He was unable to get her pants off while laying on top of her, so he got her over the bed and managed to get her pants down.
-He raped her.
-She told him she had to use the bathroom to get him to stop.
-She went to the bathroom and he left the room.
-She could not remember the exact date this occurred.

Interview with the Business Office Manager (BOM) on 08/05/22 at 12:40pm revealed Resident #10 lived in a private room on the 200 hall and had a private bath.

Telephone interview with Resident #10's family member on 08/03/22 at 10:57am revealed:
-Resident #10 told her she was raped by Resident #9 while living at the facility.
-She believed Resident #10 when she told her she was raped.
-Resident #10 told the Resident Life Coordinator (RLC) and Operations Manager (OM) she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 273	Continued From page 27	D 273		

raped the day it happened, and they did not believe Resident #10.
-Resident #10 was not sent to the hospital.
-There were no witnesses to the incident.
-Resident #10 was discharged from the facility not long after she told staff about the rape.

Telephone interview with Resident #10's Guardian on 08/05/22 at 10:58am revealed:
-Resident #10 was like a seven-year old in her ability to understand and make decisions.
-The court had said Resident #10 was incompetent.

Interview with Resident #9 on 08/03/22 at 2:42pm revealed:
-Resident #10 was his girlfriend.
-Their relationship included a lot of hugging and kissing.
-He asked Resident #10 for sex "once" and she said no.
-He had been in Resident #10's room alone with her.
-He hugged her on the bed in her room.
-They had agreed not to have sex.
-They had not broken that agreement.

Review of Resident #10's Accident/Injury Report dated 04/26/22 at 1:00pm revealed:
-The Accident/Injury report was documented as prepared by the OM on 04/26/22.
-Type of injury was documented as "none present."
-There was no documentation the resident was taken to the emergency room (ER) for evaluation.
-There was no documentation the resident's primary care provider was notified.
-There was no documentation the resident's family member, responsible party were notified.
-There was no documentation of a date or time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 28	D 273		

the incident occurred.
-Resident #10 went to the RLC and stated a male resident had been sexually inappropriate with her.
-RLC brought Resident #10 into the OM's office to discuss reported incident.
-Resident #10 stated a male resident came in to her room and was touching her breasts, her leg, and then her private area and she did not want him to do that and she told him to stop and he did not stop touching her at that moment and Resident #10 proceeded to state "so I was raped."
-Prior to going into her room resident stated they had been kissing and she considered herself his girlfriend.
-Resident admitted she had been boyfriend/girlfriend with male resident but did not want to be anymore.
-RLC and OM encouraged Resident #10 to stay away from Resident #9 and Resident #9 to also stay away from her.

Review of Resident #10's Accident/Injury Report dated 04/26/22 at 2:05pm revealed:
-Resident#10 complained of chest pain.
-Resident #10 was sent to the ER via emergency medical services (EMS) to a local hospital for evaluation.
-Resident #10's Guardian was notified on 04/26/22 at 1:57pm.

Telephone interview with a medication aide (MA) on 08/03/22 at 2:06pm revealed:
-Resident #10 came to her to talk.
-She did not remember the date when this occurred.
-Resident #10 alleged Resident #9 raped her.
-Resident #10 said she and Resident #9 had their clothes on when it occurred.
-Resident #10 said Resident #9 penetrated her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 273	Continued From page 29	D 273		

and then pointed to her navel area.
-The MA texted the OM and told her about what Resident #10 said about being raped.

Interview with a personal care aide (PCA) on 08/03/22 at 3:14pm revealed:
-Resident #10 told a group of staff (including two MAs and the PCA) in the medication room that Resident #9 had raped her.
-He did not remember the date when this occurred.
-He and some other staff then went and spoke with Resident #9.
-Resident #9 said he did not do it.
-He and some other staff brought Resident #10 and Resident #9 into the same room together to talk about it.
-When Resident #10 was confronted by Resident #9, her story changed.
-Resident #10, after confronted by Resident #9 and staff, stated "So, can I say he touched me?"

Interview with the OM on 08/04/22 at 9:35am revealed:
-She became aware of Resident #10's allegation of rape when the resident came to speak with their RLC on 04/26/22.
-The RLC called her into the meeting with Resident #10.
-Resident #10 told them Resident #9 was her boyfriend and he started touching her and she did not want him to.
-She said they were kissing, and Resident #9 touched her breast, her leg, and in her private area and she did not want to do that.
-She asked Resident #10 if Resident #9 had tried to take her clothes off and she said no.
-She asked Resident #10 if Resident #9 had penetrated her and she said no.
-Resident #10 could not tell them when it had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 273	Continued From page 30	D 273		

happened.
-She interviewed several staff to ask about the incident.
-Staff interviews confirmed Resident #10 and Resident #9 had been seen on multiple occasions hugging, kissing, and touching each other in various common areas of the facility.
-It looked to staff as if they were boyfriend and girlfriend.
-The facility did not have a written policy concerning what actions to take after an allegation of rape.
-She did not have any training on assessing sexual assault victims.
-Their employees had not received any training on assessing sexual assault victims.
-Their normal process after an allegation of rape included obtaining details of what happened and by interviewing the residents involved, notifying the guardian of the alleged rape, and contacting law enforcement.
-Law enforcement would have several recommendations.
-Typically, the resident would go to the hospital and later she would find out a sexual assault kit had been obtained.
-Staff who were made aware of an allegation of rape were responsible to report it to management using an Employee Responsibility to Report form and submit it using the chain of command.
-She did not receive a form from staff for this incident.
-She did not notify Resident #10's primary care provider (PCP) of the allegation of rape made on 04/26/22.
-She did not notify Resident #10's PCP because the resident was a recent admission (04/21/22) and was not an established patient with the PCP.
-She became aware of Resident #10's allegation of rape when the resident came to speak with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 273	Continued From page 31	D 273		

RLC on 04/26/22.
-Resident #10 was a new admission (04/21/22) when the rape allegation was made to her on 04/26/22.
-Resident #10 did not have a mental health provider when the allegation was made.
-Mental health crisis may have been contacted to assist Resident #10.
-She did not see a mental health crisis visit note for Resident #10 for 04/26/22.
-If mental health crisis had been notified of Resident #10's allegation, she could not remember any recommendations made concerning Resident #10.

Interview with the OM on 08/03/22 at 4:40pm revealed:
-Resident #10 was not taken for emergency medical evaluation due to an allegation of rape.
-It was her understanding that during the encounter with Resident #9 on 04/26/22 there was no penetration.
-She did not notify law enforcement of the allegation of rape.

Telephone interview with the RLC on 08/03/22 at 1:14pm revealed:
-Resident #10 came to him on 04/27/22 to talk with him about an alleged rape which had occurred.
-Resident #10 told him Resident #9 came to her room and laid on her on her bed.
-Resident #9 started kissing and touching her and it took him some time to leave.
-Resident #9 supposedly touched her breast and crotch area and "it scared" Resident #10 and she withdrew her consent.
-Resident #10 told him neither she nor Resident #9 had removed any clothing during the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 273	Continued From page 32 Interview with the RLC on 08/04/22 at 10:13am revealed: -He became involved in a discussion with Resident #10 on 04/27/22 after the resident came to him and said she was raped. -When he first started speaking with Resident #10, she used the word "rape" several times. -As he asked Resident #10 more questions, in his opinion, she meant kissing. -At no time did Resident #10 indicate clothes came off and there was sexual intercourse. -Hearing from staff, the OM, and Resident #10, at no time did anyone claim the clothes came off and there was sexual intercourse. -He did not have any training on assessing sexual assault victims. -He did not remember the date he notified Resident #10's Guardian or family member of the rape allegation. -The OM probably reached out to Resident #10's Guardian to inform him of the allegation of rape. -He did not contact Resident #10's PCP about the allegation of rape. -The OM was responsible for notifying the PCP. Review of the RLC's Daily Notes entry dated 04/27/22 revealed: -Resident #10 asked to speak with RLC, upset with male peer kissed/touched her without her consent. -RLC informed Resident #10, she did not have to put up with anything she did not want, and he would talk to peer. -There was no documentation Resident #10's PCP was made aware of the sexual assault allegation or that Resident #10 was upset with male peer related to his touching her without her consent. Telephone interviews with Resident #10's	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 33 Guardian on 08/03/22 at 10:35am and 08/04/22 at 11:20am revealed: -He was guardian of the person for Resident #10. -Resident #10 called him and a family member on 04/26/22 to report complaints of chest pain. -Facility staff did not mention Resident #10 had alleged rape on 04/26/22 by Resident #9. -Facility staff did not ask him for permission to send Resident #10 to the hospital for emergency medical evaluation. -On 05/02/22, he received a call from the RLC. -The call was on speaker phone and Resident #10 was in the room. -During this call, he was told by the RLC Resident #10 had said Resident #9 was trying to kiss her. -Resident #10 spoke up and said, "That's not all he did." -The Guardian said to Resident #10, "you need to try to get along." -Resident #10 replied to the Guardian "What? Should I sleep with everybody down here?" -That was when the RLC explained to him, Resident #10 was giving conflicting statements. Telephone interview with Resident #10's PCP on 08/03/22 at 2:20pm revealed: -He visited the facility to see residents on 04/21/22. -He did not see Resident #10 on that day, because the resident was admitted to the facility after he left the facility. -He was Resident #10's PCP and would have seen her on his next visit to the facility on 05/05/22, but she had already been discharged from the facility. -Resident #10 would have needed a sexual assault examination immediately after an allegation of rape. -He was not notified of Resident #10's allegation of rape.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 34 -The facility staff should have notified him immediately of the allegation of rape so he could make recommendations for interventions. Review of Resident #10's Accident/Injury Report dated 05/02/22 revealed: -The Accident/Injury report was documented as prepared by the OM on 05/04/22. -Resident #10 hit another female resident due to Resident #10 being on the phone and other resident asking to use it. -Resident #10 stated she was talking to a family member. -Resident #10 became agitated and threatened self-harm. -Mental health crisis was contacted and responded. Review of Resident #10's mental health crisis visit notes from 04/26/22 to 05/04/22 revealed: -Mental health crisis responded to visit Resident #10 on 05/02/22 at 1:15pm. -There was no other documented mental health crisis visit notes for 04/26/22 to 05/04/22 for Resident #10. -On the visit on 05/02/22, Resident #10 reported to be suicidal due to her perception that no one was taking her seriously when she told staff another male resident made sexual advances towards her and even had sex with her which led her to think she was pregnant. Review of Resident #10's RLC Daily Notes entry dated 05/02/22 revealed: -Resident #10 stated a peer came into her room last Thursday (04/28/22) and kissed her repeatedly, although she said "no." -Resident #10 stated that she had told him that she "needs love" and had kissed him willingly the day before.	D 273		

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	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 35 -RLC informed Resident #10 that she may be sending him "mixed signals." -RLC encouraged Resident #10 to stay away from peer, unless she wants to be in a romantic relationship with him. -Resident #10 stated suicidal ideation. -RLC facilitated a call to Resident #10's Guardian, who requested medication adjustment/increase and stated these behaviors are her pattern. -RLC facilitated a call to Resident #10's family member which was not answered. -RLC encouraged Resident #10 to take an as needed medication and walked with the resident to the medication room. -RLC observed Resident #10 appropriately request and take the dose of as needed medication. -The OM and Resident #10 spoke and again the resident stated suicidal ideation. -RLC facilitated her to call mental health crisis. -Mental health crisis responded and visited Resident #10 in person approximately 90 minutes later. -After interaction with mental health crisis, Resident #10 stated she felt better, and OM assisted her to speak with family member by phone. Review of Resident #10's RLC Daily Notes entry dated 05/03/22 revealed: -Resident #10 was mildly depressed, stated she wanted to relocate to another residence because nobody liked her "here." -The RLC discussed effective coping strategies with the resident which included calling a family member, taking as needed medications, walking outside, and coloring to de-escalate. -Resident #10 had several more contacts throughout the day with the RLC and stated she was going to elope and be homeless.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

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D 273	Continued From page 36	D 273		

-The RLC arranged for Resident #10 to meet with her prior mental health provider who had worked with Resident #10 in the recent past.
-The RLC spoke with Resident #10's prior mental health provider after the meeting between her and Resident #10.
-The mental health provider stated she did not think Resident #10 was going to hurt herself and she made a medication adjustment to help Resident #10's emotional lability.

Review of Resident #10's mental health provider progress note dated 05/03/22 revealed:
-Resident #10 was admitted to their service on 04/29/22 and discharged on 05/17/22.
-On 05/03/22, Resident #10 was seen for a routine psychiatry follow-up visit.
-Resident #10 was reported to be suicidal with a plan and wanting to leave the facility due to rejection from the man with whom she was trying to form a relationship.
-There was no documentation the rape allegation was reported to the mental health provider during the on-site visit on 05/03/22.
-There were no other documented psychiatric visit notes from 04/29/22 to 05/04/22.

Review of Resident #10's RLC Daily Notes entry dated 05/04/22 at 1:00am revealed:
-Resident #10 stated she wanted to go to the hospital for heart pain.
-Staff checked Resident #10's blood pressure and it was normal.
-A personal care aide (PCA) told Resident #10 she did not need to go to the hospital and the resident struck the PCA with her fist and attempted to elope several times.
-Resident #10 stated she wanted razor blades so she could cut her wrists.
-Resident #10 stated she would assault a female

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	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 37	D 273		

peer.
-Resident #10 threw her belongings into the hall.
-Mental health crisis was called and responded in person to complete involuntary commitment (IVC) petition on Resident #10.
-Law enforcement transported Resident #10 to the ER for evaluation on 05/04/22 at 9:00am.

Review of Resident #10's Guardian's notes from 04/26/22 to 05/04/22 revealed:
-On 04/26/22, Resident #10 called with complaints of her heart hurting; the Administrator said she would have her checked out.
-On 04/28/22, the Guardian and a family member visited Resident #10 at the facility.
-On 04/29/22, Resident #10 called and asked for the Guardian to come get her and take her out of the facility.
-On 05/02/22, mental health crisis called for consent to interview Resident #10 because she was making suicidal comments.
-On 05/03/22, a family member said Resident #10 had told her she had sex with a man at the facility; Resident #10 would be seeing a psychologist "today" (05/03/22).
-On 05/04/22 at 4:15am, the Guardian received a call about Resident #10 needing mental health crisis.
-On 05/04/22 at 7:30am, the Guardian received a call from mental health crisis requesting permission to take Resident #10 to the hospital for mental evaluation by local law enforcement due to resident being a danger to herself and flight risk.

Review of facility 911 call report from 04/21/22 to 05/04/22 revealed:
-There were no calls related to an allegation of rape.
-There were three entries which specifically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 38	D 273		

referred to Resident #10.
-On 04/26/22, there was a call reporting Resident #10 was complaining of chest pains.
-On 04/29/22, there was a call reporting Resident #10 had complaints of low blood sugar, dizziness, light-headed, and sick.
-On 05/04/22, there was a call requesting a magistrate for IVC for Resident #10.

Review of Resident #10's local emergency medical services (EMS) reports from 04/21/22 to 05/04/22 revealed there were no calls related to an allegation of rape.

Telephone interview with the local county 911 communications center on 08/05/22 at 10:52am revealed they did not receive any calls to report rape or sexual assault involving Resident #10 from 04/21/22 to 05/04/22.

Attempted interview with Resident #10's prior mental health provider on 08/08/22 at 11:01am was unsuccessful.

Refer to telephone interview with the RLC on 08/03/22 at 1:14pm.

Refer to interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm.

Refer to interview with the OM on 08/02/22 at 10:11am.

Refer to interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am.

2. Review of Resident #2's current FL2 dated 12/02/21 revealed diagnoses included [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 39 Review of local law enforcement 911 call log dated 03/31/22 revealed: -There was a call received at 6:49pm in reference to a disturbance. -Resident #2 was listed as very combative. -The incident involved a physical disturbance. -Documented facility staff were trying to keep all other patients and staff away from Resident #2. Review of Resident #2's Mental Health Nurse Practitioner (NP) orders dated 04/12/22 revealed additional diagnoses of [redacted] Review of Resident #2's primary care provider (PCP) progress note dated 04/21/22 revealed an additional diagnosis of [redacted]. Review of Resident #2's Resident Register revealed an admission date of 05/12/21. Review of Resident #2's Care Plan dated 05/19/22 revealed: -[redacted].	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 40 Review of Resident #2's Resident Life Coordinator (RLC) Daily Notes dated 04/11/22 revealed: -He was agitated, delusional, upset that he was not prescribed the same meds as he was during a previous stay at a local psychiatric hospital. -Stated he was going to his room to cry. -[redacted]. Review of Accident/Injury Report dated 04/12/22 for Resident #2 revealed: -Another resident approached Resident #2, "sticking him in the upper right side". -Resident #2 and the other resident had an altercation and were separated by staff. -Resident #2 received three stitches in the local hospital emergency department and was transported back to the facility. Review of Resident #2's RLC Daily Notes dated 04/12/22 revealed: -Resident was stabbed with a small pocketknife by another resident. -Emergency Management Services (EMS) evaluated, transported to emergency department (ED), and returned to facility. -Was delusional, grandiose, mood labile. -Admitted to using synthetic marijuana, unwilling to discontinue, unwilling to discuss possible medication interaction or impact on mental illness. Review of Resident #2's MHRN visit note dated 07/05/22 revealed: -[redacted]	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 41	D 273		

[redacted]

Review of Resident #2's Mental Health LCSW visit note dated 07/07/22 revealed:

-[redacted].

Review of Resident #2's Accident/Injury Report dated 07/09/22 at 9:11pm revealed:

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CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

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D 273	Continued From page 42 -There was attached documentation dated 07/10/22 from the Operations Manager (OM), stating she observed camera footage on 07/10/22 where Resident #2 was observed becoming very aggressive, leaving another resident laying on the 100-hall porch as he walked away. -Administrator was notified and then law enforcement. -While waiting on response from law enforcement Resident #2 was monitored closely via live camera feed. -At approximately 2:30pm Resident #2 was taken into custody by local law enforcement. -Immediate discharge was sent to Resident #2's guardian via email which had been requested by telephone. Review of Resident #2's MHRN visit note dated 07/09/22 revealed: [redacted] Review of Resident #2's RLC Daily Notes dated 07/11/22 revealed there was a conversation with the OM and also with the Medication Aide (MA) Supervisor regarding Resident #2's physical assault of a female peer on 100 hall porch after a brief verbal exchange, punching, kicking and stomping her head. Review of local law enforcement 911 call log dated 07/10/22 revealed: -At 2:19pm, a call was received in reference to an assault. -The incident happened last night at 9:00pm. -Suspect listed in the report was Resident #2.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 273	Continued From page 43 Telephone interview with the MA Supervisor on 08/05/22 at 10:52am revealed: -Resident #2 had delusions and would often comment [redacted] -On 07/05/22 she was in the medication room with a PCA, a MA and a MHRN when Resident #2 stated he was going to hurt someone to get out of there so he could go get back to jail [redacted] -She should have reported this to the OM or RCC. -The MHRN did not say anything to Resident #2 after statement was made but did write something down. -She expected the MHRN to report Resident #2's threats to his Mental Health Provider (MHP). -She stated the MHRN should have completed Involuntary Commitment (IVC) paperwork on Resident #2. -She could not complete IVC paperwork and expected the MHRN to complete it. -She did not report Resident #2's statement until after the RCC returned to work after being out on leave. -She should have called mental health crisis and notified his MHP. Interview with the Resident Care Coordinator (RCC) on 08/03/22 at 2:30pm revealed: -She was notified by the MA Supervisor on 07/11/22, when she returned to work after being out on leave, of Resident #2's statement made related to potentially harming others. -The MA Supervisor should have reported this to mental health crisis. -She did not know if anyone had notified the OM, Primary Care Provider (PCP) or MHP. -Staff should have notified the PCP or MHP. -She did not notify anyone when Resident #2's statement was reported to her.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 44 Telephone interview with a personal care aide (PCA) on 08/05/22 at 1:05pm revealed: -On 07/05/22 he was in the medication room with a MA, MA supervisor, and the MHRN when Resident #2 stated "he was going to have to hurt someone to get out of there so he could go back to jail". -He told resident #2 that he didn't want to do that. -He did not report Resident #2's statement regarding potential harm to someone to any additional staff. Telephone interview with a medication aide (MA) on 08/05/22 at 1:49pm revealed: -Resident #2 did have delusions and would often comment [redacted]. -On 07/05/22 she was in the medication room with a PCA the MA Supervisor and a MHRN when Resident #2 stated he was going to have to hurt someone to get out of there so he could go back to jail. -She stated the MHRN did not say anything to Resident #2 regarding potential harm to someone. -She or the MA Supervisor should have reported this to the OM or the RCC. -She or the MA Supervisor should have called mental health crisis and notified his MHP. -She did not report Resident #2's statement to any additional staff. -She did not fill out an Accident/Incident report regarding Resident #2's statement of potential harm to others on 07/05/22. Interview with the OM on 08/03/22 at 3:28pm revealed: -She was not aware that Resident #2 had made a statement regarding potential harm to other people.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 45 -Staff should have immediately notified mental health crisis. -Staff should have notified Resident #2's PCP or MHP. Review of Resident #2's record revealed there was no documentation of the PCP, MHP, and mental health crisis being notified of the incident on 07/05/22. Telephone interview with Resident #2's Mental Health NP on 08/05/22 at 2:24pm revealed: -[redacted] Telephone interview with Resident #2's PCP on 08/02/22 at 1:11pm, 08/04/22 at 3:14pm and 08/09/22 at 1:23pm revealed: -[redacted]	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 273	Continued From page 46 [redacted] Interview with a local law enforcement deputy on 07/28/22 at 5:15pm revealed: -He was the responding officer on 07/10/22 when Resident #2 assaulted another resident. -After he viewed the facility video footage of Resident #2 assaulting another resident, he immediately called a detective. -[redacted].	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 47 Interview with a local law enforcement detective on 07/29/22 at 9:31am revealed: -She was the responding detective on 07/10/22 when Resident #2 assaulted another resident after receiving a call from the deputy. -She viewed the facility video footage of Resident #2 assaulting another resident. -She asked Resident #2 why he assaulted another resident and he stated the facility was drugging him and because the other resident had asked him to kill her. -Blood was found on the shoes and shorts Resident #2 was wearing in the video during the assault. -Resident #2 stated that prison was going to be better than being at the facility, at least there will be air conditioning, while sitting in the Operations Manager's (OM) office. -She asked Resident #2 if he and the other resident who he assaulted were friends and Resident #2 stated he didn't want to say anything else that would jeopardize his competency hearing. -Resident #2 had a criminal history which included, driving under the influence (DUI), marijuana possession, assault and battery, assault on a government official, resisting arrest and communicating threats. -She stated she remembered an altercation with a staff member at the facility. Interview with a Registered Nurse (RN) at the county jail on 08/02/22 at 4:03pm revealed: -[redacted]	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 48 Interview with the Resident Life Coordinator (RLC) on 08/04/22 at 10:00am revealed: -Resident #2 had consistent behaviors but could be erratic at times. -Resident #2 had good days and then there were times he was very angry and delusional about who he was. -The facility suspected drug abuse and Resident #2 was smoking Delta-8 daily. -Resident #2 was intelligent and knew what he wanted. -Resident #2 had become aggressive with a female staff a couple of months ago. -The aggressive behavior towards female staff was addressed with the resident. -Resident #2 never verbalized any threats to harm others to the RLC. Telephone interview with the OM on 08/08/22 at 3:10pm revealed: -If staff overheard a verbal threat made by a resident or if a resident had a change in behavior, she expected the MA Supervisor to call mental health crisis. -She expected staff to increase supervision of that resident until mental health crisis had completed their evaluation and made recommendations. -She was not aware that Resident #2 had made a statement regarding potential harm to other people on 07/05/22. -If she had been notified by staff of the verbal threat made by Resident #2 on 07/05/22, and they had not called mental health crisis, she would have instructed them to do so. -She did not expect the MA Supervisor to notify her if they called mental health crisis. Refer to telephone interview with the RLC on 08/03/22 at 1:14pm.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 49 Refer to interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm. Refer to interview with the OM on 08/02/22 at 10:11am. Refer to interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision] _____ Telephone interview with the RLC on 08/03/22 at 1:14pm revealed his job duties included keeping the residents happy, retention of residents, keep down unacceptable resident behaviors, keep staff happy, and to help keep residents safe. Interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm revealed: -She was responsible for the overall management of the facility. -The Administrator and the Owner were both on vacation and she would be our primary contact person. -She had worked in the facility since 2007. Interview with the OM on 08/02/22 at 10:11am revealed the Administrator and the Owner remained on vacation this week and she would continue to be our primary contact person. Interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am revealed: -The RLC would be left in charge during any of her absence from the facility. -The Administrator remained unavailable. _____ The facility failed to notify the primary care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 273	Continued From page 50 physician and make an appropriate referral to mental health services for Resident #10 after an allegation of sexual assault. Subsequently, Resident #10 experienced an escalation in her behaviors due to her perception that no one at the facility believed her allegation, and ultimately Resident #10 was involuntarily committed for psychiatric services for being a danger to herself and others. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on August 12, 2022. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION WILL NOT EXCEED SEPTEMBER 11, 2022.	D 273		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the threatening resident to protect others from harm; (3) seek any needed emergency medical treatment; (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and	D 456		

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	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 456	Continued From page 51 (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to contact law enforcement, make a referral to mental health services, provide additional supervision of the threatening resident, and seek emergency medical treatment for 3 of 7 sampled residents (Residents #10, #9, and #2) following an allegation of a physical assault and a risk of a physical assault to the local law enforcement authority, related to Resident#10 who alleged another resident sexually assaulted her, Resident #9 who was alleged to have sexually assaulted another resident, and Resident #2 who verbalized a threat to harm others so he could leave the facility and go to jail. The findings are: 1. Review of Resident #10's Accident/Injury Report dated 04/26/22 at 1:00pm revealed: -Type of injury was documented as "none present." -There was no documentation of a date or time the incident occurred. -There was no documentation the resident was taken to the emergency room (ER) for evaluation. -There was no documentation the resident's primary care provider was notified. -There was no documentation the resident's family member, responsible party were notified. -Resident #10 went to the Resident Life Coordinator (RLC) and stated a male resident	D 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 456	Continued From page 52	D 456		

had been sexually inappropriate with her.
-RLC brought Resident #10 into the Operations Manager's (OM) office to discuss reported incident.
-Resident #10 stated a male resident came in to her room and was touching her breasts, her leg, and then her private area and she did not want him to do that and she told him to stop and he did not stop touching her at that moment and Resident #10 proceeded to state "so I was raped."
-Prior to going into her room resident stated they had been kissing and she considered herself his girlfriend.
-Resident admitted she had been boyfriend/girlfriend with male resident but did not want to be anymore.
-RLC and OM encouraged Resident #10 to stay away from this male resident and male resident to also stay away from her.

Review of a male resident's Accident/Injury Report dated 04/26/22 revealed:
-The RLC and OM met with a male resident to discuss an incident reported by Resident #10 (alleged victim).
-A male resident and Resident #10 were boyfriend and girlfriend.
-Resident #10 wanted the male resident to stay away from her.
-The male resident agreed to stay away from Resident #10.
-There was no documentation on the report of a rape allegation made against the male resident.
-There was no documentation on the report that law enforcement had been notified.

Review of Resident #10's FL2 dated 04/05/22 revealed:
-Diagnoses included intellectual disability, anxiety,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 456	Continued From page 53	D 456		

depression, and conduct disorder and outburst.
-The resident was ambulatory.

Review of Resident #10's Resident Register revealed:
-There was an admission date of 04/21/22.
-The resident had a guardian of the person.

Review of Resident #10's Care Plan dated 05/02/22 revealed:
-The resident was documented as oriented with adequate memory.
-The resident required limited assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Telephone interview with Resident #10 on 08/03/22 at 10:42am revealed she was raped when she lived at the facility.

Telephone interview with Resident #10's family member on 08/03/22 at 10:57am revealed:
-Resident #10 told her she was raped by a male resident while living at the facility.
-She believed Resident #10 when she told her she was raped.
-Resident #10 told the Resident Life Coordinator (RLC) and Operations Manager (OM) she was raped the day it happened, and they did not believe her.

Telephone interviews with Resident #10's Guardian on 08/03/22 at 10:35am revealed:
-He was guardian of the person for Resident #10.
-Facility staff did not mention Resident #10 had made an allegation of rape on 04/26/22 by a male resident.
-He did not find out about the alleged rape until after Resident #10 was discharged from the facility.

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	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 456	Continued From page 54 Telephone interview with a MA on 08/03/22 at 2:06pm revealed: -Resident #10 came to her to talk. -Resident #10 alleged a male resident raped her. -She did not remember the date when this occurred. -The MA texted the OM and told her about what Resident #10 said about being raped. Interview with a personal care aide (PCA) on 08/03/22 at 3:14pm revealed: -Resident #10 told a group of staff (including two MAs and the PCA) in the medication room that a male resident raped her. -He did not remember the date when this occurred. -When the MAs questioned Resident #10, she got "real emotional" when the staff asked her details about the incident. -The MAs were responsible to report the incident to management. Interview with the OM on 08/04/22 at 9:35am revealed: -She became aware of Resident #10's allegation of rape when the resident came to speak with the RLC on 04/26/22. -The RLC called her into the meeting with Resident #10. -Resident #10 told them a male resident was her boyfriend and he started touching her and she did not want him to. -She said they were kissing, and he touched her breast, her leg, and in her private area and she did not want to do that. -She asked Resident #10 if the male resident had tried to take her clothes off and she said no. -She asked Resident #10 if he had penetrated her and she said no.	D 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 456	Continued From page 55	D 456		

-Resident #10 could not tell them when it had happened.
-She interviewed several staff to ask about the incident.
-Staff interviews confirmed Resident #10 and a male resident had been seen on multiple occasions hugging, kissing, and touching each other in various common areas of the facility.
-It looked to staff as if they were boyfriend and girlfriend.
-The facility did not have a written policy concerning what actions to take after an allegation of rape.
-Their employees had not received any training on sexual assault victims.
-Their normal process after an allegation of rape included obtaining details of what happened and by interviewing the residents involved.
-They would then contact the guardian and report the alleged rape.
-Typically, the resident would go to the hospital and later she would find out a sexual assault kit had been obtained.
-Staff who were made aware of an allegation of rape were responsible to report it to management using an Employee Responsibility to Report form and submit it using the chain of command.
-She did not receive a form from staff for this incident.

Telephone interview with the local county 911 communications center on 08/05/22 at 10:52am revealed they did not have any calls involving Resident #10 and reported allegations of rape or sexual assault from 04/21/22 to 05/04/22.

Telephone interview with the RLC on 08/03/22 at 1:14pm revealed:
-Resident #10 came to him on 04/27/22 to talk with him about an alleged rape which had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 456	Continued From page 56	D 456		

occurred.
-Resident #10 told him a male resident came to her room and laid on her on her bed.
-The male resident started kissing and touching her and it took him some time to leave.
-There was no written policy on resident who had guardian's and their sexual involvement with other residents.
-The male resident supposedly touched her breast and crotch area and "it scared" Resident #10 and she withdrew her consent.

Interview with the OM on 08/03/22 at 4:40pm revealed:
-Resident #10 was not taken for an emergency medical evaluation due to an allegation of rape.
-It was her understanding during the encounter with the male resident on 04/26/22, there was no penetration.

Review of Resident #10's local emergency medical services (EMS) reports for 04/21/22 to 05/04/22 revealed:
-There were three EMS reports involving Resident #10 for 04/21/22 to 04/26/22.
-There were no entries related to a reported allegation of rape or sexual assault involving Resident #10.

Refer to telephone interview with the RLC on 08/03/22 at 1:14pm.

Refer to interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm.

Refer to interview with the OM on 08/02/22 at 10:11am.

Refer to interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 456	Continued From page 57 2. Review of Resident #9's current FL2 dated 02/17/22 revealed diagnoses included a history of head trauma, traumatic brain injury, and schizoaffective disorder. Review of Resident #9's physician's orders dated 03/28/22 revealed an additional diagnosis of schizophrenia. Review of Resident #9's Care Plan dated 02/03/22 revealed: -Resident #9 had a history of mental illness and was receiving medications for mental illness/behavior. -There was no documentation of behavioral issues. -Resident #9 was oriented with an adequate memory and ambulated independently. Review of Resident #9's Accident/Injury Report dated 04/26/22 revealed: -The RLC and OM met with Resident #9 to discuss an incident reported by a female resident (alleged victim). -Resident #9 and a female resident were boyfriend and girlfriend. -The female resident wanted Resident #9 to stay away from her. -Resident #9 agreed to stay away from the female resident. -There was no documentation on the report of a rape allegation made against Resident #9. -There was no documentation on the report that law enforcement had been notified. Telephone interview with a medication aide (MA) on 08/03/22 at 2:06pm revealed: -A female resident had come to the MA to talk. -She did not remember the date when this	D 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 456	Continued From page 58	D 456		

occurred.
-The female resident alleged Resident #9 raped her.
-The female resident told the MA, she and Resident #9 had their clothes on when it occurred.
-The female resident told the MA, Resident #9 penetrated her and then pointed to her navel area.
-The MA texted the Operations Manager (OM) and told her about what the female resident said about being raped.

Review of the facility 911 call report from 03/01/22 to 04/30/22 revealed a sexual assault allegation against Resident #9 had not been reported.

Telephone interview with the MA supervisor on 08/08/22 at 10:10am revealed she had been very busy the day of the rape allegation assisting with the female resident's behaviors.

Telephone interview with the Resident Care Coordinator (RCC) on 08/08/22 at 10:40am revealed:
-She had not been involved in the incident and did not know anything about it.
-There were not any care notes in the record for the alleged assault.
-The Resident Life Coordinator (RLC) and OM were involved in investigating the incident.

Telephone interview with the RLC on 08/08/22 at 11:45am revealed:
-He had spoken to Resident #9 and the female resident about the rape allegation.
-The OM was responsible for informing staff of any interventions for Resident #9 as he was not involved in that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	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 456	Continued From page 59 Telephone interview a third shift MA on 08/08/22 at 1:00pm revealed she knew there had been an allegation that Resident #9 had raped a female resident. Interview with the OM on 08/04/22 at 9:35am and 08/08/22 at 3:10pm revealed: -She became aware of a female resident's allegation of rape when the resident came to speak with the RLC on 04/26/22. -The RLC called her into the meeting with the female resident. -The female resident told them Resident #9 was her boyfriend and he started touching her and she did not want him to. -The facility did not have a written policy concerning what actions to take after an allegation of rape. -Their employees had not received any training on sexual assault victims. -Their normal process after an allegation of rape included obtaining details of what happened and by interviewing the residents involved. -Then they would contact law enforcement. -Law enforcement would have several recommendations. -Staff who were made aware of an allegation of rape were responsible to report it to management using an Employee Responsibility to Report form and submit it using the chain of command. -She did not receive a form from staff for this incident. -She had spoken to Resident #9 and the female resident and had determined it was not necessary to contact law enforcement as she believed the rape had not occurred. -She had instructed both residents to stay away from each other. Attempted telephone interview with Resident #9's	D 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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 456	Continued From page 60 mental health provider (MHP) on 08/11/22 at 9:34am was unsuccessful. Refer to telephone interview with the RLC on 08/03/22 at 1:14pm. Refer to interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm. Refer to interview with the OM on 08/02/22 at 10:11am. Refer to interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am. 3. Review of Resident #2's current FL2 dated 12/02/21 revealed diagnoses included [redacted] Review of Resident #2's Mental Health Nurse Practitioner's (NP) orders dated 04/12/22 revealed and additional diagnosis of [redacted] Review of Resident #2's Primary Care Provider's (PCP) progress note dated 04/21/22 revealed an additional diagnosis of [redacted]. Review of Resident #2's Resident Register revealed an admission date of 05/12/21. Review of Resident #2's Care Plan dated 05/19/22 revealed: -[redacted]	D 456		

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	HAL059021	A. BUILDING: _____ B. WING _____	C 08/12/2022

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D 456	Continued From page 61 [redacted]. Review of local law enforcement 911 call log dated 03/31/22 revealed: -There was a call received at 6:49pm in reference to disturbance. -Resident #2 was listed as very combative. -The incident involved a physical disturbance. -Documented facility staff were trying to keep all other patients and staff away from Resident #2. Review of Resident #2's MHRN note dated 07/09/22 revealed the resident [redacted] Review of local law enforcement 911 call log for 07/10/22 revealed: -A call was received at 2:19pm in reference to an assault. -The incident happened last night at 9:00pm. -Suspect listed in the report was Resident #2. Telephone interview with a personal care aide (PCA) on 08/05/22 at 1:05pm revealed on 07/05/22 he was in the medication room with a medication aide (MA), MA supervisor, and the Mental Health Registered Nurse (MHRN) when Resident #2 stated "he was going to have to hurt someone to get out of there so he could go back to jail". Telephone interview with a MA on 08/05/22 at 1:49pm revealed: -She was in the medication room with a PCA, the MA Supervisor and the MHRN on 07/05/22 when	D 456		

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D 456	Continued From page 62 Resident #2 stated he was going to have to hurt someone to get out of there so he could go get back to jail. -She stated the MHRN did not respond to Resident #2 regarding his statement for potential harm to others. a. Telephone interview with a MA on 08/05/22 at 1:49pm revealed: -She or the MA Supervisor should have initiated 15-minute checks on Resident #2. -She or the MA Supervisor should have reported this to the Operations Manager (OM) or the Resident Care Coordinator (RCC). Telephone interview with MA Supervisor on 08/05/22 at 10:52am revealed: -She should have initiated 15-minute checks on Resident #2 but did not when Resident #2 made statement regarding potentially harming others on 07/05/22. -She should have reported this to the OM or RCC. Interview with the RCC on 08/03/22 at 2:30pm revealed: -She was notified by the MA Supervisor on 07/11/22, when she returned to work after being out on leave, of Resident #2's statement made related to potentially harming others. -Staff should have initiated 15-minute checks on Resident #2. Interview with the OM on 08/03/22 at 3:28pm revealed: -She was not aware that Resident #2 made a statement regarding potential harm to others on 07/05/22. -Staff should have initiated 15-minute checks on Resident #2.	D 456		

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D 456	Continued From page 63 Telephone interview with the OM on 08/08/22 at 3:10pm revealed: -If staff overheard a verbal threat made by a resident or if a resident had a change in behavior, she expected staff to increase supervision of that resident until mental health crisis had completed their evaluation and made recommendations. -She was not aware that Resident #2 had made a statement regarding potential harm to other people on 07/05/22. b. Telephone interview with a personal care aide (PCA) on 08/05/22 at 1:05pm revealed he did not report Resident #2's statement regarding potential harm to someone to any additional staff. Telephone interview with a MA on 08/05/22 at 1:49pm revealed: -She or the MA Supervisor should have called mental health crisis and notified his Mental Health Provider (MHP). -She did not report Resident #2's statement regarding potential harm to others to any additional staff. Telephone interview with MA Supervisor on 08/05/22 at 10:52am revealed: -She did not report Resident #2's statement until after the RCC returned to work after being out on leave. -She should have called mental health crisis and notified his MHP. Interview with the RCC on 08/03/22 at 2:30pm revealed: -She was notified by the MA Supervisor on 07/11/22, when she returned to work after being out on leave, of Resident #2's statement made related to potentially harming others.	D 456		

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D 456	Continued From page 64	D 456		

-The MA Supervisor should have reported this to mental health crisis.
-She did not know if anyone had notified the PCP or MHP.
-Staff should have notified Resident #2's PCP or MHP.
-She did not notify anyone when Resident #2's statement of potentially hurting someone was reported to her by the MA Supervisor.

Interview with the OM on 08/03/22 at 3:28pm revealed:
-She was not aware that Resident #2 made a statement regarding potential harm to others on 07/05/22.
-Staff should have immediately notified the MHP and mental health crisis.
-Staff should have notified Resident #2's PCP or MHP regarding Resident #2's statement regarding potential harm to others on 07/05/22.

Review of Resident #2's record revealed there was no documentation of the PCP, MHP, and mental health crisis being notified of the incident on 07/05/22.

Telephone interview with the OM on 08/08/22 at 3:10pm revealed:
-If staff overheard a verbal threat made by a resident or if a resident had a change in behavior, she expected the MA Supervisor to call mental health crisis.
-She was not aware that Resident #2 had made a statement regarding potential harm to other people on 07/05/22.
-If she had been notified by staff of the verbal threat made by Resident #2 on 07/05/22, and they had not called mental health crisis, she would have instructed them to do so.
-She did not expect the MA Supervisor to notify

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D 456	Continued From page 65 her if they called mental health crisis. Telephone interview with Resident #2's Mental Health NP on 08/05/22 at 2:24pm revealed: -[redacted] Interview with Resident #2's PCP on 08/04/22 at 3:14pm and on 08/09/22 at 1:23pm revealed: -[redacted]	D 456		

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D 456	Continued From page 66	D 456		

[redacted]

Refer to telephone interview with the RLC on 08/03/22 at 1:14pm.

Refer to interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm.

Refer to interview with the OM on 08/02/22 at 10:11am.

Refer to interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am.

[Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision]

[Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care]

_____

Telephone interview with the RLC on 08/03/22 at 1:14pm.revealed his job duties included keeping the residents happy, retention of residents, keep down unacceptable resident behaviors, keep staff happy, and to help keep residents safe.

Interview with the OM on 07/28/22 at 4:20pm, 6:03pm, and 6:28pm revealed:
-She was responsible for the overall management of the facility.
-The Administrator and the Owner were both on vacation and she would be our primary contact person.
-She had worked in the facility since 2007.

Interview with the OM on 08/02/22 at 10:11am revealed the Administrator and the owner remained on vacation this week and she would continue to be our primary contact person.

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D 456	Continued From page 67 Interview with the OM on 8/11/22 at 11:00am, 11:08am and 11:30am revealed: -The RLC would be left in charge during any of her absence from the facility. -The Administrator remained unavailable. The facility failed to seek the assistance of law enforcement, make a referral for mental health services, obtain any needed emergency medical treatment, and provide additional supervision to 3 of 7 sampled residents (#10, #9 and #2) when there was a risk of death or physical harm to occur due to the actions and behaviors of residents. The facility failed to seek the assistance of law enforcement, obtain mental health services and any needed emergency medical treatment for Resident #10 after she alleged that Resident #9 sexually assaulted her. Subsequently, Resident #10 experienced an escalation in her behaviors due to her perception that no one at the facility believed her allegation, and ultimately Resident #10 was involuntarily committed for psychiatric services for being a danger to herself and others. Additional supervision was not provided and referrals for mental health services or emergency mental health treatment were not made by the facility after Resident #2 verbalized a threat to harm someone so that he could leave the facility and go to jail. Subsequently, Resident #2 brutally attacked another resident, causing the resident to be admitted to the Intensive Care Unit at the hospital and then be discharged to a skilled nursing facility due to a traumatic brain injury as a result of the beating. These failures by the facility resulted in substantial risk of serious physical harm to residents and constitutes a Type A2 Violation.	D 456		

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D 456	Continued From page 68 The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on August 12, 2022. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION WILL NOT EXCEED SEPTEMBER 11, 2022.	D 456		
D912	G.S. 131D-21(2) Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and reporting of accidents and incidents. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 9 sampled residents (Resident #2) after the resident, who had a history of aggressive behavior, exhibited an escalation in behavior, and was known to be using illicit drugs, verbalized a threat to harm someone so he could leave the facility and go to jail. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D912		

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D912	Continued From page 69 2. Based on interviews and record reviews, the facility failed to contact law enforcement, make a referral to mental health services, provide additional supervision of the threatening resident, and seek emergency medical treatment for 3 of 7 sampled residents (Residents #10, #9, and #2) following an allegation of a physical assault and a risk of a physical assault to the local law enforcement authority, related to Resident#10 who alleged another resident sexually assaulted her, Resident #9 who was alleged to have sexually assaulted another resident, and Resident #2 who verbalized a threat to harm others so he could leave the facility and go to jail. [Refer to Tag 0456, 10A NCAC 13F .1212(g) Reporting of Accidents and Incidents (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free of neglect related to health care. The findings are: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 6 sampled residents (Residents #10 and #2) related to the facility's failure to notify the primary	D914		

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D914	Continued From page 70 care provider and make a referral to appropriate mental health services after an allegation of a sexual assault (Resident #10), and failure to notify the primary care provider, mental health provider, and mental health crisis provider of a verbal threat made by a resident to harm someone so he could leave the facility and go to jail (Resident #2). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D914		