STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 and the Yadkin County Department of Social Services conducted a complaint investigation from 10/24/23 to 10/27/23. The complaint was initiated by the Yadkin County Department of Social Services on 10/20/23.	D 000		
D 226	10A NCAC 13F .0702(b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident shall be based on one of the following reasons: (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and	D 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 1	D 226		

interviews, the facility failed to issue a discharge for 2 of 2 sampled residents (Resident #2 and #3) related to a resident who endangered himself and others with multiple emergency rooms visits for an involuntary commitment (IVC) obtained by local law enforcement and mental health mobile crisis including verbal and/or physical confrontations with staff and residents, and euphoric drug usage (#3) and a resident who had multiple instances of illegal drug usage (#2).

The findings are:

Review of the facility's Delta-8 (a cannabis compound that produces a euphoric high similar to marijuana) Policy revealed:
-There was no date listed on the policy.
-Delta-8 would not be permitted in or on facility property.
-The purchase or use of these products on community property would result in confiscation and report to guardian and all relevant physicians.
-If the resident did not abide by the guidelines of this policy, the resident would be subject to discharge.
-Staff would counsel the resident and would invite the attending physician in determining whether the resident could continue to participate in activities or have other privileges while they resided in the community.

1. Review of Resident #3's current FL2 dated 10/12/23 revealed diagnoses included intellectual disability, obesity, adjustment disorder, and autistic disorder.

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 10/26/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 2	D 226		

Review of Resident #3's progress notes revealed there were 15 incidents of behaviors documented for Resident #3 between 06/05/23 to 09/28/23.

Review of the facility's Incident/Accident Injury Report Form for Resident #3 dated 07/03/23 at 4:40pm revealed:
-Resident #3 had an altercation (fight) with another resident, 911 was called after the 2 were separated and the guardian was called.
-Resident #3 was sent to the hospital (B).
-There was documentation from the Facility Manager that the "facility will issue a 30 day transfer/discharge notice due to the resident being violent toward other residents". The facility (is) working in coordination with the guardian to find proper placement. Awaiting Administrator approval.

Review of local Emergency Medical Services (EMS) reports for Resident #3 revealed there were 5 incidents where EMS was dispatched to pick up Resident #3 at the facility between 07/01/23 to 10/17/23.

Review of local law enforcement reports revealed there were 4 law enforcement encounters documented for Resident #3 between 06/03/23 to 07/11/23.

Review of Resident #3's hospital discharges and after visit summaries revealed there 5 hospital visits documented related to physical altercations and behaviors between 07/03/23 to 10/16/23 :

Review of the facility's policy on Delta-8 (a cannabis compound that produces a euphoric high similar to marijuana)consumption revealed:
-Delta-8 would not be permitted in or on the property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 3 -If policy was not followed, the resident would be subject to discharge. Review of the facility's sign out and in policy revealed: -Please be aware that non-compliance with the facility sign out policy would result in discharge from the facility. -Residents could sign out and leave between 8:00am and 8:00pm. -All signed out residents were required to be in the facility after 9:00pm. -No sign outs after 9:00pm unless it was with a family or friend for overnight stay. Observation during exit from the facility on 10/26/23 at 4:53pm revealed Resident #3 was crossing the street at an intersection between 2 major highways approximately 2 miles from the facility. Observation of the facility's resident sign-out sheet on 10/27/23 at 9:00am revealed Resident #3 had not signed out on 10/26/23 at 4:30pm. Review of the facility's resident sign-out sheets available for review revealed: -There were no sign-out sheets available for review prior to September 2023. -Sign-out sheets for various days were missing for September 2023 and October 2023. -There was no documentation Resident #3 signed out on the days he had police reports, EMS reports and/or hospital after visit summaries. Interview with Resident #3's Mental Health Provider (MHP) on 10/24/23 at 11:00am revealed: -Resident #3 signed himself out to go outside the facility.	D 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 4	D 226		

-The facility called or messaged him a lot regarding Resident #3's incidents and behaviors.
-The mental health mobile crisis also provided onsite care for residents including Resident #3.
-The mental health mobile crisis did not routinely leave in-depth information for documentation of interventions.

Telephone interview with Resident #3's MHP on 10/25/23 at 2:09pm revealed:
-He had not attempted to limit Resident #3's signing out ability because he felt Resident #3 was cognitive of his surroundings and able to find his way from and back to the facility.
-He did not think the facility could stop him from signing out and leaving when he wanted to.
-He knew Resident #3 smoked Delta-8 and drank alcohol when he went out of the facility because he had advised the resident of the dangers with mixing alcohol and Delta-8 with his medications.
-He tried to provide the facility, including Resident #3, with medications that would help with anxiety.

Telephone interview with Resident #3's guardian on 10/25/23 at 4:40pm revealed:
-He was aware there had been multiple incidents of confrontations with other residents, being outside the facility without signing out, smoking Delta-8 and hospital visits.
-Resident #3 had a history of substance abuse and had been removed from facilities in the past for inappropriate behaviors.
-He was aware of multiple IVC paperwork for mental evaluations.
-He had been trying to find different placement for Resident #3 for several months.
-He took Resident #3 for a placement interview as recent as 10/11/23 but the facility did not accept him.
-He considered it helpful that he had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 5	D 226		

discharged so that he could continue to seek placement.

Interview with Resident #3 on 10/26/23 at 11:00am revealed:
-He asked if he could be taken to his family member's house today. "I really want to get out of the facility."
-He "will not stop smoking Delta 8 or drinking (alcohol) because they help him feel better; medicine does not help".

Interview with the Chief of the local law enforcement on 10/26/23 at 2:00pm revealed:
-The department had responded to several calls as noted in the EMS and police call logs related to Resident #3's various incidents.
-The local police staff had numerous citizens calls related to Resident #3 knocking on residential doors, appearing at the court house, city fire department and various other locations.
-Resident #3 had been found outside of the facility and returned on some occasions without a report filed as a "citizen assist".
-Resident #3's numerous incidents had occupied police officers' time preventing routine patrols placing the community at risk for unprotected time periods.
-In addition, he was concerned for the welfare of Resident #3 when he was out late at night alone.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 3:20pm revealed:
-Resident #3's guardian had tried to place him in a different environment for several months.
-Resident #3's guardian had texted her to have him ready to go out to visit other facilities recently.
-Resident #3 would probably benefit from a different environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 6	D 226		

Telephone interview with the Regional Ombudsman on 10/27/23 at 9:22am revealed:
-The Ombudsman was routinely involved in assisting with placing residents that were having trouble being discharged to another facility if there was an immediate discharge.
-She had not been contacted related to an immediate discharge for Resident #3.

Interview with a resident on 10/27/23 at 9:45am revealed:
-He and Resident #3 had a confrontation a few weeks ago, date unknown.
-He thought Resident #3 believed he said something negative about him and approached him while he was in his wheelchair, yelled at him and hit him on his head and back.
-He had no other incident with Resident #3 since.

Telephone interview with a MA on 10/27/23 at 1:05pm revealed:
-She was aware Resident #3 propositioned other male and female residents for sex.
-She had found him in other female residents' rooms and made him come out.
-She redirected him when she saw him approach other residents.

Interview with the Operations Manager (OM) on 10/27/23 at 3:10pm revealed:
-Resident #3 was issued IVC paperwork requested by either mental health mobile crisis, or the local law enforcement.
-He was told the Administrator the facility could not issue an immediate discharge because Resident #3's IVCs were rescinded by the hospital mental health evaluations.
-The facility had been trying to work with the guardian to seek placement in another facility, but the facility and the guardian had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 7	D 226		

successful.
-He was told in the past by the Administrator and county resources that unless there was a change of level of care, Resident #3 could not be sent to another facility.
-He felt that his hands were tied for discharging Resident #3.

Interview with the Administrator on 10/27/23 at 5:10pm revealed:
-She did not know the exact procedure for immediate discharge of a resident.
-She had inquired to the local county Department of Social Services (DSS) related to the availability of the "placement team" to assist with finding a different facility for Resident #3 due to his endangering himself by continuing to use street drugs along with his prescribed medications and behaviors toward staff and other residents.
-She was informed by DSS on more than one occasion there was currently no "placement team" in existence.
-She did not know the former Resident Care Coordinator (RCC) documented that a 30-day discharge was going to be issued on 07/03/23 for behaviors that endangered other residents and himself.
-She had been in contact with Resident #3's guardian on several occasions regarding finding a suitable facility for Resident #3.
-She had not completed the official discharge paperwork along with the right to appeal and notified Resident #3's guardian because she was waiting on the guardian's successful placement of the resident.
-She provided a timeline for information provided to the guardian with 5 specific dates the guardian requested information for Resident #3 and attempting relocation of the resident to another facility as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 8	D 226		

-On 06/30/23 at 9:19am, a FL2 was emailed to the guardian.
-On 07/13/23 at 3:05pm, a FL2 was emailed to the guardian who was working on finding placement at another facility.
-On 08/18/23 and 08/28/23, the guardian requested a new FL2 to help with trying to admit the resident to a different facility.
-On 09/07/23, the guardian requested the number of qualified personal care hours and daily activity needs that were sent on 09/08/23 and again on 08/13/23.
-On 10/12/23, another current FL2 was presented to the guardian in the parking lot of the facility for placement in a group home.
-A meeting was requested with the guardian upon his return from the group home placement interview, but the guardian returned the resident to the facility parking lot and left with no meeting.
-She was issuing an immediate discharge, 30-day discharge notice and right for appeal today (10/27/23) due to the resident's intoxicated appearance at the facility at present.

Attempted telephone interview with the previous Resident Care Coordinator (RCC) on 10/27/23 at 9:38am unsuccessful.

Observation on 10/27/23 at 5:00pm revealed EMS and law enforcement officers were in the parking lot of the facility attempting to transport Resident #3 from the facilty.

2. Review of Resident #2's current FL2 dated 01/12/23 revealed:
-Diagnoses included history of schizoaffective disorder, unspecified trauma and stressor disorder, antisocial personality disorder, asthma, and intermittent explosive disorder.
-She was intermittently disoriented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 9 -She was ambulatory. Review of Resident #2's progress notes revealed 8 incidents documented of behaviors and illegal drug use between 05/20/23 to 10/23/23. Review of Resident #2's hospital visit notes dated 08/04/23 revealed: -Resident #2 tested positive for fentanyl and marijuana on a urine drug screen. -Resident #2 reported to hospital staff that she smoked marijuana. -Resident #2 denied fentanyl usage and stated that it "must have been in her marijuana." Review of Resident #2's incident/accident report dated 09/05/23 at 5:35pm revealed: -Resident #2 and another resident were observed in a physical altercation. -Resident #2 stated that a male resident was shoving her, so Resident #2 hit the male resident in the face. -The male resident reacted to Resident #2 by kicking her. -Resident #2 stated that she fell to the floor to protect herself. -Resident #2's guardian was notified by leaving a message by phone. Telephone interview with Resident #2's guardian on 10/26/23 at 9:15am revealed: -She was currently Resident #2's guardian and had been for years. -Resident #2 was signing out whenever Resident #2 left the facility to her knowledge prior to 07/17/23. -Resident #2 had a couple of altercations with other residents since she had moved into the facility. -Resident #2 had not tried to harm herself but	D 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 10	D 226		

Resident #2 did make suicidal comments to staff to be sent out to the hospital.
-Resident #2 had a pattern of being sent out to the hospital for suicidal ideation, "taking a couple hours break" from the facility and coming back to the facility.
-She did not know that Resident #2 had ongoing occurrences of smoking marijuana outside on facility property.

Interview with Resident #2 on 10/27/23 at 10:40am revealed:
-She had never seen any illegal substances inside the building.
-The last time she had used marijuana was about two months ago.
-She had used marijuana but had never used fentanyl.
-She had used marijuana outside of the facility property but had never used marijuana inside the facility.
-Staff had held a group meeting with the residents a few months ago and staff told the residents that they would be discharged for illegal drug usage as it was not allowed.

Interview with a resident on 10/26/23 at 8:40am revealed:
-In September 2023, (date unknown), she saw Resident #2 with marijuana.
-When Resident #2 saw her on the same occasion, she told her she better not touch her "stuff" or she would beat her up.
-Resident #2 then told her she was going to flush the marijuana, but she did not witness her flush or smoke the marijuana.
-She just stayed away from Resident #2 after she threatened her and told her guardian about the incident.
-She did not tell staff about the marijuana or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 11	D 226		

Resident #2 threatening her.

Interview with a personal care aide (PCA) on 10/27/23 at 11:10am revealed:
-She had never seen any of the residents with marijuana and had never caught any of the residents smoking inside the facility.
-She had smelled the scent of marijuana on Resident #2's person as Resident #2 had walked by her before.
-She had never seen Resident #2 try to fight with any of the other residents.

Interview with a second PCA on 10/27/23 at 4:58pm revealed:
-He had smelled marijuana on Resident #2's person and "seen her loopy" but he was not sure if it was marijuana, CBD (an active ingredient in cannabis that is derived from hemp plant), or Delta-8.
-He had not seen any of the residents with marijuana but he had seen the Delta-8 vaping pens passed around frequently.
-PCAs reported incidents to the medication aides (MA), MAs reported incidents to the Resident Care Coordinator (RCC), and the RCC reported incidents to the Administrator.

Interview with Resident #2's primary care provider (PCP) on 10/27/23 at 11:38am revealed:
-She knew that several residents had tested positive for marijuana usage on urine drug screens, including Resident #2.
-She did not know that Resident #2 tested positive for fentanyl on a urine drug screen when Resident #2 went out to the hospital on 08/04/23.
-She was concerned for the residents' safety after learning that some of the residents had tested positive for fentanyl on a urine drug screen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 12 Telephone interview with Resident #2's mental health provider (MHP) on 10/27/23 at 11:58am revealed: -Staff notified him that Resident #2 was caught smoking marijuana several times. -He felt that Resident #2 may be more appropriately placed at a group home due to Resident #2's self-destructive behaviors. -He thought a smaller environment may be better for Resident #2. Interview with the RCC on 10/27/23 at 3:50pm revealed: -She became the RCC three weeks ago. -The former RCC took the lead on notifying the providers about positive urine drug screens for fentanyl and marijuana. -She put all the residents' paperwork from the hospital in a box for the providers to see when the providers visited residents at the facility. -The previous RCC had let her know that Resident #2 had tested positive for fentanyl and marijuana at the hospital on 08/04/23. -She had not notified the Operations Manager (OM) or the Administrator that Resident #2 tested positive for fentanyl and marijuana because she was not the RCC at that time. -No one had told her about a timeframe for when residents were supposed to have a second urine drug screen after they tested positive. Interview with the OM on 10/27/23 at 2:40pm revealed: -He did not know that Resident #2 tested positive on a urine drug screen for fentanyl and marijuana after a hospital emergency room visit on 08/04/23. -He did not know about any instances of Resident #2 being caught smoking marijuana by facility staff.	D 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 13 -He expected staff to let him know immediately if residents were caught with illegal drugs. -He and the Administrator would have issued a 30-day discharge notice to Resident #2 if they had known that there were repeated instances of Resident #2 using illegal substances. Interview with the Administrator on 10/27/23 at 2:45pm revealed: -They had caught some of the residents with illegal drugs before. -She knew that Resident #2 was caught by facility staff with marijuana or Delta-8 in the past but she did not know that Resident #2 was found smoking marijuana by facility staff on 10/23/23. -She expected staff to let her know immediately if residents were caught with illegal drugs. -She and the OM would have issued a 30-day discharge notice to Resident #2 if they had known that there were repeated instances of Resident #2 using illegal substances. Attempted telephone interview with the previous Resident Care Coordinator (RCC) on 10/27/23 at 9:38am unsuccessful. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. _____ The facility failed to ensure an immediate discharge for 2 sampled residents related to a resident who threatened to harm himself, had physical altercations, inappropriate sexual behaviors toward other residents and using illegal drugs at the facility (#3), and a resident using illegal drugs at the facility and threatening other residents (#2). This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.	D 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 226	Continued From page 14 The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/26/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 11, 2023.	D 226		
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 observations, record reviews, and interviews, the facility failed to provide supervision for 3 of 6 sampled residents (#2, #3, and #5) including a resident who had inappropriate sexual behaviors, and aggressive behaviors resulting in the resident physically and verbally assaulting other residents (#3); a resident who left facility property without supervision from staff (#2); and a resident who was physically aggressive towards another resident resulting in the other resident being hit in the head with a cane (#5). The findings are: Review of the facility's policy for resident	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 15	D 270		

supervision revealed there no policy available for review.

Review of the facility's policy on Delta-8 (a cannabis compound that produces a euphoric high similar to marijuana) consumption revealed:
-Delta-8 would not be permitted in or on the property.
-If policy was not followed, the resident would be subject to discharge.

Review of the facility's sign out and in policy revealed:
-Please be aware that non-compliance with the facility sign out policy would result in discharge from the facility.
-Residents could sign out and leave between 8:00am and 8:00pm.
-All signed out residents were required to be in the facility after 9:00pm.
-No sign outs after 9:00pm unless it was with a family or friend for overnight stay.

1. Review of Resident #3's current FL2 dated 10/12/23 revealed diagnoses included intellectual disability, obesity, adjustment disorder, and autistic disorder.

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 10/26/22.

Review of Resident #3's Care Plan with an assessment date of 10/10/23 and signed on 10/12/23 revealed:
-Resident #3 was sometimes disoriented, forgetful, and adequate for hearing and vision.
-Resident #3 was independent for ambulation and transferring; needed limited assistance with eating; and needed limited assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 16	D 270		

toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #3's progress notes revealed the following behaviors documented for Resident #3 revealed:
-On 06/03/23 at 4:53pm, Resident #3 was apprehended by local law enforcement at a house close to the facility after an event with the homeowner resulting in Resident #3 being arrested for an additional altercation with the local law enforcement.
-On 06/05/23 at 3:12am, Resident #3 was sent to a local hospital, administered medication to calm him down and returned to the facility on 06/04/23 at 8:30pm with a court date citation for incident with the hospital security guard.
-On 06/06/23 at 3:12pm, Resident #3 was seen by a psychiatric provider and ordered a medication for anxiety at 2:00pm daily.
-On 07/01/23 at 5:36pm, Resident #3 became physically aggressive with another resident. Police were called but the police said to call mental health mobile crisis for IVC. Mental Health mobile crisis said it would be 2 hours until their arrival; resident kept threatening to harm himself and others so 911 was called again. EMS found the resident lying in the road. The guardian was called, and he asked that Resident #3 be taken to the hospital for a psychiatric evaluation.
-On 07/01/23 at 9:28pm, Resident #3 appeared back at the facility via medical UBER, still slightly agitated.
-On 07/03/23 at 6:00pm, local law enforcement and Emergency Medical Services (EMS) were called for Resident #3 who was trying to hit another resident and using inappropriate language. Resident was transported to a second local hospital for evaluation.
-On 07/11/23 at 11:44pm, Resident #3 told the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 17	D 270		

medication aide (MA) he wanted to walk to the local gas station; the MA tried to redirect but the resident went out to walk anyway.
-On 07/12/23 at 1:10am, the MA called to report an elopement, but local law enforcement stated Resident #3 was getting an IVC for making suicidal threats in front of law enforcement, so EMS was called but the resident resisted going with EMS. IVC was obtained and the resident was waiting on transport to a third local hospital .
-On 07/12/23 at 2:54am, the local law enforcement called to say Resident #3 was transported to the third local hospital for IVC.
-On 07/12/23 at 2:00pm, the third local hospital called to say they were sending the resident back by local law enforcement or the facility would have to come pick up the resident.
On 07/12/23 at 9:04pm, Resident #3 told staff another resident was chasing him and making threats.
-On 07/12/23 at 9:14pm, Resident #3 was cussing and yelling at staff and trying to put his hands on a male staff.
-On 07/14/23 at 3:00am, Resident #3 left the facility after 1:00am rounds and was returned by local sheriff officer stating the resident was found trying to hitch hike to his hometown.
-On 07/15/23 at 12:34am, Resident #3 kept walking off from the facility; went out this evening. Resident #3 said he did not want to be here and other residents were trying to hurt him. Staff tried to redirect the resident.
-On 7/15/23 at 1:12am, the local law enforcement returned Resident #3 to the facility from a local fire department about one mile away.
-On 07/16/23 at 1:46pm, Resident #3 was "horseplaying around" and sustained a punch to his eye. An ice pack was applied.
-On 07/16/23 at 4:49pm, Resident #3 was in an altercation with another resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 18	D 270		

-On 08/05/23 at 2:01am, Resident #3 was returned to the facility at 12:00am by local law enforcement; the MA had driven around town trying to find the resident earlier.
-On 08/26/23 at 6:35pm, Resident #3 was observed just off of the property smoking Delta-8 (a cannabis compound that produces a euphoric high similar to marijuana) with 2 other residents.
-On 09/04/23 at 11:06am, Resident #3 was just off of the property line smoking Delta-8.
-On 09/04/23 at 11:05pm, Resident #3 was picked up by the local police for an IVC due to earlier physical altercations with staff.
-On 09/28/23 at 9:30pm, Resident #3 asked to be IVC' ed. The MA said she could not make that decision on her own.
-On 09/28/23 at 10:03pm, Resident #3 was at the local courthouse (1 mile away) with the local law enforcement. EMS was called and Resident #3 was sent to a fourth local hospital.
-On 10/16/23 at 2:50am, the third local hospital called to tell facility staff Resident #3 was brought to the hospital by the local police.

Interview with a female resident on 10/26/23 at 8:40am revealed:
-Resident #3 had made unwanted sexual advances toward her.
-Once in September 2023, (unknown date), he pushed her down on the couch in the television room and got on top of her and said an [inappropriate sexual comment].
-He tried to pull her into his room, touch her breasts and asked her to have sex with Resident #3 on numerous occasions since she was admitted in August 2023.
-There were no witnesses and she did not tell staff in fear of retaliation from Resident #3.

Interview with a male resident on 10/27/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 19 9:45am revealed: -He and Resident #3 had a confrontation a few weeks ago, (date unknown). -He thought Resident #3 believed he said something negative about him and approached the resident while he was in his wheelchair, yelled at him and hit him on his head and back. -He had no other incident with Resident #3 since. Interview with Resident #3's roommate on 10/27/23 at 9:50am revealed: -Resident #3 had not physically abused him. -He was not sure if Resident #3 was in the room at night because he was asleep. -Resident #3 called him mean names sometimes. -He did not stay in his room during the day, he was in the television room or sitting outside of the facility most days, so he did not have to be around Resident #3. Observation after leaving the facility for the day on 10/26/23 at 4:53pm revealed Resident #3 was in the grassy median at an intersection of 2 major highways approximately 2 miles from the facility. Resident #3 appeared to be making his way through the intersection but was not in the road at the time. Observation of the facility's resident sign-out sheet on 10/27/23 at 9:00am revealed Resident #3 had not signed out on 10/26/23 at 4:30pm. Review of Resident #3's record revealed there was no documentation the facility was aware he was out of the facility on 10/27/23. Review of the facility's 2 hour check documentation and midnight census check sheets revealed: -The facility had documentation that staff were	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 20	D 270		

completing and documenting 2 hour checks.
-The 2 hour check sheets were scanned into the facility's computer system for accountability.
-Resident #3 was included on the list of residents receiving routine 2 hour checks.

Review of Resident #3's progress notes revealed there was no documentation for increased supervision after Resident #3 returned from hospital visits or local law enforcement returned him after leaving the facility without the staff knowing his whereabouts or that he was gone.

Telephone interview with Resident #3's mental health provider (MHP) on 10/25/23 at 2:09pm revealed:
-He had not attempted to limit Resident #3's signing out ability because he felt Resident #3 was cognitive of his surroundings and able to find his way from and back to the facility.
-He did not think the facility could stop him from signing out and leaving when he wanted to.
-He knew Resident #3 smoked Delta-8, and drank alcohol when he went out of the facility because he had advised the resident of the dangers with mixing alcohol and Delta-8 with his medications.
-The facility did not have the resources to do one on one supervision to keep him from leaving without signing out.
-He or a team member was available by phone or messages, and a team member for the mental health service was on call 24 hours a day.
-He tried to provide the facility, including Resident #3, with medications that would help with anxiety and behaviors toward others.

Telephone interview with Resident #3's guardian on 10/25/23 at 4:40pm revealed:
-He was aware there had been multiple incidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 21	D 270		

of confrontations with other residents, being outside the facility without signing out, smoking Delta-8 and hospital visits.
-Resident #3 had a history of substance abuse and had been removed from facilities in the past for inappropriate behaviors.
-He was aware of multiple IVC paperwork for mental evaluations.
-He had not recommended additional supervision because he thought Resident #3 would go and come regardless of the restrictions.

Interview with the Chief of the local law enforcement on 10/26/23 at 2:00pm revealed:
-The department had responded to several calls as noted in the EMS and police call logs related to Resident #3's various incidents.
-The local police department had numerous citizens calls related to Resident #3 knocking on residential doors, appearing at the court house, city fire department and various other locations.
-Resident #3 had been found outside of the facility and returned on some occasions without a report filed as a "citizen assist".
-Resident #3's numerous incidents had occupied police officers' time preventing routine patrols placing the community at risk for unprotected time periods.
-In addition, he was concerned for the welfare of Resident #3 when he was out late at night alone.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 3:20pm revealed:
-Resident #3 could be redirected from confrontations with residents sometimes, but not always.
-Resident #3 usually did not have violent behaviors toward other residents but did get into verbal confrontations often.
-Resident #3 would leave without signing out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 22	D 270		

the facility to go up town or to the local gas station that sold Delta-8.
-Facility staff had repeatedly asked Resident #3 to sign out so that staff knew when he was gone and where he was headed.
-His guardian had not restricted his privileges to sign out and go and come as he desires.
-There had been no additional supervision other than staff were always looking to see where Resident #3 was located in the facility during the routine 2 hour checks and random at other times.

Interview with a personal care aide (PCA) on 10/27/23 at 11:20am revealed:
-She had observed Resident #3 in a female resident's room approximately 2 weeks ago, sitting on the end of her bed.
-She redirected Resident #3 and told him he should not be the female resident's room.
-No resident had told her Resident #3 had inappropriate sexual behaviors toward them.
-The PCA and MAs did 2 hour resident checks for care and location of residents.
-Resident #3 needed prompting for showers.
-She had smelled alcohol on Resident #3's breath before and a smell similar to that of Delta-8 on his clothing.
-She had observed him acting intoxicated when he walked by staggering and shuffling.
-She was not aware of any additional supervision provided for Resident #3.

Telephone interview with the Supervisor/medication aide (S/MA) on 10/27/23 at 1:15pm revealed:
-Newly admitted residents had told her in the past that Resident #3 propositioned other male and female residents for sex.
-She had found him in other female residents' rooms and would make him come out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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		

-The facility staff did 2 hour resident checks and document on the facility's form.
-She would redirect him when she saw Resident #3 approach other residents.
-Staff had tried to redirect and/or deescalate his inappropriate behaviors, but occasionally ended up calling mental health mobile crisis to intervene with his behaviors.
-She frequently reminded Resident #3 he needed to sign out when he left the facility.
-She had personally gone out of the facility to pick up Resident #3 at different locations around the facility.
-Resident #3's guardian was aware of the resident's many incidents and non-compliance with signing out when leaving the facility.
-In conversations with the guardian, she had been asked to "try to keep him supervised".
-The facility staff tried to keep Resident #3 in the facility, but they could not force him to stay in the facility.
-Resident #3's behaviors changed when he returned to the facility and Resident #3 smelled like he had been drinking alcohol or smoking Delta-8.
-Facility staff , including her, knew to look for Resident #3 in the facility throughout the day and night because he would go out walking without signing out.

Interview with Resident #3's primary care provider (PCP) on 10/27/23 at 11:40am revealed:
-She had never seen drugs other than medications ordered for residents in her visits to the facility.
-She was familiar with Resident #3's multiple incidents involving local law enforcement and inappropriate behaviors outside the facility from after visit summaries in the resident's record and health care provider notes within her computer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 24	D 270		

system.
-She had noticed Resident #3 smelled like he had been around Delta-8 smoke.
-Resident #3's behaviors were more related to his mental health conditions and should be addressed by the MHP.
-She had not recommended any additional supervision for Resident #3 because he had mental health services through their health care provider.

Telephone interview with a supervisor with the local mental health mobile crisis team on 10/27/23 at 12:10am revealed:
-The mobile crisis team was contracted by the local mental health management entity.
-The mobile crisis team could be contacted 24 hours a day for 7 days a week.
-When a call was received by the mobile crisis team, the team was supposed to respond within 2 hours maximum time.
-The team tried to respond within 15 minutes to assist with the mental health need but sometimes, based on staff location and situational workload it could be 2 hours.
-The mobile crisis team could obtain IVC paperwork from the magistrate's office.
-The supervisor was not able to supply specific information for Resident #3's incidents.

Interview with the Administrator on 10/27/23 at 3:00pm revealed:
-There was no additional supervision in place for Resident #3.
-Staff tried to make sure they knew where he was.
-Sometimes he told staff he was leaving and signed out and sometimes he just left the facility.
-She had been working with Resident #3's guardian to find placement due to his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 25	D 270		

non-compliance with the sign-out policy, altercations with residents, and Delta-8 and alcohol issues.
-The guardian or the MHP had not restricted his signing out to leave the facility and he would not be compliant if they did.

Refer to the interview with the Operations Manager on 10/27/23 at 2:40pm.

Refer to the interview with the Administrator on 10/27/23 at 3:00pm.

2. Review of Resident #2's current FL2 dated 01/12/23 revealed:
-Diagnoses included history of schizoaffective disorder, unspecified trauma and stressor disorder, antisocial personality disorder, asthma, and intermittent explosive disorder.
-She was intermittently disoriented.
-She was ambulatory.

Review of Resident #2's care plan dated 01/12/23 revealed:
-She required limited assistance for eating, dressing, bathing, grooming, and transferring.
-She required supervision with toileting and ambulation.

Review of Resident #2's progress notes revealed:
-On 05/20/23 at 1:23am, Resident #2 was caught outside smoking marijuana with a male resident.
-On 05/29/23 at 10:31pm, personal care aides (PCAs) informed the medication aide (MA) that Resident #2 was outside of the facility smoking what appeared to be marijuana with another female resident. The MA went to check on the residents and found them off the property. When the MA approached Resident #2, she started yelling in the street that she could smoke what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 26	D 270		

she wanted and she did not have to follow facility policy. The MA tried to talk to Resident #2 but Resident #2 stated that if staff did not let her do what she wanted that she was going to make false accusations about staff.
-On 07/17/23 at 2:34pm, Resident #2 returned to the facility. Resident #2 knew her guardian sent a note to the facility stating Resident #2 could not leave the facility without staff supervision.
-On 08/04/23 at 1:22am, Resident #2 told the MA that she was having auditory and visual hallucinations. Resident #2 asked to be sent out to the hospital. Resident #2 stated that she "needed a break." Staff called and left a voicemail for Resident #2's guardian.
-On 08/18/23 at 9:12pm, Resident #2 was found by staff outside smoking marijuana or Delta-8 (a cannabis compound that produces a euphoric high similar to marijuana).
-On 08/20/23 at 10:19pm, Resident #2 was caught by staff with 2 other residents smoking something that smelled like marijuana. A cigarette was confiscated by staff.
On 09/05/23 at 5:35pm, Resident #2 and another resident were observed in a physical altercation. Resident #2 stated that a male resident was shoving her and Resident #2 hit the male resident in the face. The male resident reacted to Resident #2 by kicking her.
-On 10/23/23 at 11:28pm, Resident #2 was smoking marijuana or Delta-8 on facility property.

Review of Resident #2's record revealed:
-There was an email dated 07/17/23 at 1:29pm from Resident #2's guardian addressed to the facility.
-The email stated: "Per our telephone conversation earlier today, I'm writing to request that [Resident #2] not be able to leave the facility grounds unless she is supervised by staff."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 27 Interview with Resident #2 on 10/27/23 at 10:40am revealed: -She smoked cigarettes and cigars and the last time she had used marijuana was two months ago. -She never brought any illegal substances into the facility. -If she used vapes, she bought them at the local store. Observation of Resident #2 on 10/27/23 at 4:26pm revealed: -Resident #2 was outside and walked off the facility property while Emergency Medical Services (EMS) was at the facility. -Resident #2 walked down the street away from the facility. Observation of Resident #2 on 10/27/23 at 4:46pm revealed: -Resident #2 was outside and returned to the facility from the way she had gone. -Resident #2 was gone from the facility and off facility property for 20 minutes without supervision from staff. Interview with a personal care aide (PCA) on 10/27/23 at 4:50pm revealed: -Resident #2 was outside sitting on the grass on 10/27/23 which was the last time that she had seen Resident #2. -She did not know that Resident #2 had left the facility for 20 minutes. Interview with a second PCA on 10/27/23 at 4:58pm revealed: -He last saw Resident #2 sitting in the grass under a tree on 10/27/23. -EMS arrived at the facility and he was helping	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 28	D 270		

EMS personnel.
-The next time he saw Resident #2 she was inside the facility.
-He did not know that Resident #2 left the facility for 20 minutes.

Interview with the Resident Care Coordinator (RCC) on 10/27/23 at 5:10pm revealed:
-Resident #2 left the facility daily to go to the store, and sometimes left 2 or 3 times daily.
-Staff was aware that Resident #2 was still leaving the facility unsupervised.
-She did not know Resident #2 left the facility for 20 minutes on 10/27/23.
-Resident #2's guardian was aware that Resident #2 still left the facility.

Interview with the Administrator on 10/27/23 at 5:20pm revealed:
-She did not know that Resident #2's guardian sent a letter to the facility requesting that Resident #2 not leave the facility without supervision from staff.
-She did not know Resident #2 left the facility for 20 minutes on 10/27/23 without supervision.
-All staff were responsible to monitor Resident #2 and attempt to redirect her from leaving facility grounds if they saw Resident #2 leaving.

Attempted telephone interview with the facility's previous Resident Care Coordinator (RCC) on 10/27/23 at 9:38am unsuccessful.

Refer to the interview with the Operations Manager (OM) on 10/27/23 at 2:40pm.

Refer to the interview with the Administrator on 10/27/23 at 3:10pm.

3. Review of Resident #5's current FL2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 29 03/09/23 revealed: -Diagnoses included hypertension, schizophrenia, and vascular dementia. -He was ambulatory and intermittently disoriented. -He was admitted to the facility on 05/25/22. Review of Resident #5's care plan dated 06/12/23 revealed: -He required limited assistance with eating and toileting. -He required supervision with ambulation and transferring. -He required extensive assistance with bathing, dressing and grooming. Review of Resident #5's incident/accident report dated 05/03/23 revealed: -Resident #5 came to the medication room at 10:30pm on 05/03/23 and asked the medication aide (MA) for a cigarette. -The MA told Resident #5 there were no cigarettes to give out at the time. -Resident #5 got upset and went outside to the patio. -Resident #5 asked another resident for a cigarette and the other resident told him no. -Resident #5 got mad, took the other resident's cane, and hit the other resident in the head with the cane. -The other resident stated he was fine. -The residents were separated. Review of Resident #5's progress note dated 05/03/23 at 10:30pm revealed: -Resident #5 came to the medication room at 10:30pm on 05/03/23 and asked the MA for a cigarette. -The MA told Resident #5 there were no cigarettes to give out at the time.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 30	D 270		

-Resident #5 got upset and started yelling and cussing at staff.
-Resident #5 went outside, grabbed another resident's cane, and hit the other resident in the head with the cane.
-Resident #5 went inside to his room.
-Mental health mobile crisis was called and the facility was waiting on a call back.
-The other resident stated he was fine and did not want to go to the hospital.

Attempted interview with the staff who completed the incident report dated 05/03/23 unsuccessful.

Review of Resident #5's incident/accident report dated 02/04/23 at 6:15pm revealed:
-Resident #5 was observed by staff cursing and screaming at other residents.
-The mental health mobile crisis was called and mental health mobile crisis representative asked the facility staff to call the local law enforcement because the mental health mobile crisis was 2 hours away.
-The local police department arrived and spoke to Resident #5 and told Resident #5 to stay away from residents with whom Resident #5 had disagreements.
-The local police department left and Resident #5 asked to call his guardian.
-Resident #5 became more upset after speaking with his guardian on the phone.
-Staff called the mental health mobile crisis and were told to call the local police department.
-The local police department came to the facility for a second time and explained to staff that there was nothing they could do except talk to Resident #5.
-A law enforcement officer spoke to Resident #5 and left.
-The mental health mobile crisis representatives

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 31	D 270		

arrived and spoke with Resident #5.
-Resident #5 started to verbally abuse the representative from the mental health mobile crisis unit.
-The representative from the mental health mobile crisis unit told the staff that she planned to petition for an involuntary commitment (IVC) for Resident #5 with the magistrate.
-The local law enforcement arrived at approximately 11:00pm and Resident #5 was removed from the facility property to be involuntarily committed.

Review of Resident #5's hospital visit notes dates 02/04/23 revealed:
-Resident #5 arrived to the hospital at 11:26pm.
-Resident #5 was brought to the hospital by a local law enforcement with (IVC) paperwork.
-Resident #5 was threatening other residents, tried to set a facility staff's hair on fire, and was throwing things at other residents.
-Resident #5 was seen by a medical doctor on 02/06/23 at 10:05am and the medical doctor determined that Resident #5 could be discharged back to the facility.

Review of Resident #5's progress note dated 06/24/23 at 3:18pm revealed:
-Resident #5 started screaming and threatening a female resident which caused a physical altercation between Resident #5 and another male resident.
-Staff separated the residents and asked the residents to calm down.

Review of Resident #5's progress note dated 09/30/23 at 10:30pm revealed:
-Resident #5 walked towards the medication room when another resident made a comment about him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 32	D 270		

-Resident #5 got upset and aggressive.
-Resident #5 pushed the other resident from behind.
-The other resident put his hands up and swung at Resident #5.
-The MA separated the residents and notified the Operations Manager (OM).

Review of Resident #5's incident/accident report dated 09/30/23 at 10:20pm revealed:
-Resident #5 walked towards the medication room when another resident made a comment about him.
-Resident #5 shoved the other resident from behind.
-The other resident swung at Resident #5.
-The MA separated the two residents.

Interview with a resident on 10/27/23 at 9:45am revealed there was no one at the facility that made them afraid of physical violence, including Resident #5.

Interview with Resident #5's roommate on 10/27/23 at 10:48am revealed:
-Resident #5 had never tried to hit him or yell at him and they got along well.
-He did not know if Resident #5 had ever tried to hit other residents.

Interview with a second resident on 10/27/23 at 10:50am revealed:
-Resident #5 had never hit her or attempted to hit her.
-Resident #5 "just yelled and cussed" and she walked away when he yelled.
-She did not feel unsafe around Resident #5.

Review of Resident #5's record revealed that there was not an incident/accident report dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 33 10/19/23 available for review. Review of Resident #5's progress note dated 10/19/23 revealed: -Resident #5 was on the patio hitting and kicking another resident that was also on the patio. Resident #5 could not be redirected. -Mental health mobile crisis had been called for the resident. Interview with the other resident involved in the altercation with Resident #5 on 10/19/23 revealed: -Resident #5 hit him in the jaw and tried to push him off a bench on 10/19/23. -The incident was unprovoked; Resident #5 "just came up and started." -Staff separated Resident #5 from him. -The incident was "upsetting and scary." -He had no injuries from the 10/19/23 incident. -Resident #5 had never tried to hit him prior to or since 10/19/23. -He kept to himself and he did not feel unsafe at the facility. Interview with a third resident on 10/26/23 at 11:55am revealed: -She witnessed Resident #5 hit and kick another male resident on the patio last week, unknown date. -Staff witnessed the incident but she did not think they did anything about it. -Resident #5 had frequent episodes of yelling at other residents for no reason, including her. Interview with a fourth resident on 10/26/23 at 8:50am revealed: -She had an incident with Resident #5, date unknown, outside the back door in which Resident #5 yelled in her face and drew back his	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 34	D 270		

fist like he was going to hit her.
-She yelled back at Resident #5 and Resident #5 left her alone.

Interview with a fifth resident on 10/26/23 at 3:30pm revealed:
-Resident #5 got loud and yelled at other residents unprovoked.
-She thought Resident #5 could not help yelling at other residents, so most of the time she ignored him and walked away from where Resident #5 was.
-Staff witnessed Resident #5 yelling every day, but she did not know what staff did about it.

Telephone interview with Resident #5's guardian on 10/27/23 at 4:27pm revealed:
-The facility had not discussed with her if there was anything else they could do for Resident #5 to reduce or prevent altercations with other residents.
-Staff had notified her about the altercations between Resident #5 and other residents.
-She thought Resident #5 "acted up" whenever he had been refusing to take his medications.

Interview with a personal care aide (PCA) on 10/27/23 at 11:10am revealed:
-She worked on 10/19/23 during Resident #5's incident.
-She did not observe the incident, but was told about it by another resident.
-Staff tried to deescalate the situation between Resident #5 and the other residents.
-The other resident told staff that Resident #5 hit the other resident in the face.
-Other residents told staff that Resident #5 kicked the other resident.
-Resident #5 "yelled and cussed" at everybody on 10/19/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 35	D 270		

-Mental health mobile crisis was called by the staff on 10/19/23, but Resident #5 would not talk to the mobile crisis team so the mobile crisis team left.

Interview with a second PCA on 10/27/23 at 4:58pm revealed:
-Resident #5 got upset when he did not have cigarettes.
-When Resident #5 was out of cigarettes, he asked other residents and staff for cigarettes.
-He had never witnessed Resident #5 hit another resident.

Telephone interview with a MA on 10/27/23 at 1:37pm revealed:
-Resident #5 got angry quickly if he did not have cigarettes.
-Resident #5 was normally redirectable.
-She had never seen Resident #5 hit another resident.

Based on observations, record review, and interviews, it was determined that Resident #5 was not interviewable.

Interview with Resident #5's primary care provider (PCP) on 10/27/23 at 11:38am revealed:
-Staff notified her once that Resident #5 had an altercation with another resident, but she could not remember when the incident happened.
-When notified of altercations between residents, she normally tried to screen for urinary tract infections and the mental health provider (MHP) would adjust psychiatric medications as necessary.

Telephone interview with Resident #5's MHP on 10/27/23 at 11:58am revealed:
-Staff notified him about altercations involving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 36	D 270		

Resident #5 and other residents.
-He thought the altercations were related to Resident #5's dementia diagnosis and that medications were less effective than they used to be due to dementia progression.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 3:15pm revealed:
-Resident #5 had dementia and would forget when he was given cigarettes.
-Resident #5 sometimes got upset when he wanted cigarettes and did not realize that he had already smoked some cigarettes.
-Resident #5 was able to be redirected most of the time.
-Resident #5 occasionally yelled at other residents, but it was not an everyday occurrence.

Attempted telephone interview with the facility's previous RCC on 10/27/23 at 9:38am unsuccessful.

Interview with the RCC on 10/27/23 at 5:07pm revealed:
-She was not aware of the incident on 05/03/23 involving Resident #5 and another resident.
-She worked on 10/19/23 during Resident #5's incident with another resident.
-A MA told her about the incident.
-She called mental health mobile crisis on 10/19/23, then left for the day.
-Resident #5 occasionally "actedup" but she felt that the other residents were safe around him.

Interview with the Operations Manager on 10/27/23 at 2:40pm revealed he was not aware of the incidents involving Resident #5 on 05/03/23 and 10/19/23.

Interview with the Administrator on 10/27/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 37 2:45pm revealed she did not know about the incidents involving Resident #5 on 05/03/23 and 10/19/23. Refer to interview with the Operations Manager (OM) on 10/27/23 at 2:35pm. Refer to interview with the Administrator on 10/27/23 at 3:30pm. Interview with the OM on 10/27/23 at 2:40pm revealed: -He managed the day to day operation of the facility. -The Administrator was between the facility and a sister facility across and down the street daily for consult and assistance. -The facility did not have a policy specific to supervision other than routine 2 hour checks for personal care and resident whereabouts. -The facility maintained 2 hour checks documentation for review. -The facility completed a daily midnight census log as well. -The facility did not have a system in place to increase supervision other than residents might be placed on increased supervision or checks after a fall or diagnosed medical condition, like urinary tract infection, for a couple of days. -The PCP or MHP or guardian could recommend restrictions to sign-out and the facility would increase supervision if requested. -The facility did not offer one on one supervision to residents. -The facility used the mental health mobile crisis team to assist with residents with behaviors that could not be redirected by facility staff. -The facility staff had received training annually for mental health behaviors.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 38 Interview with the Administrator on 10/27/23 at 3:10pm revealed: -The facility policy was for no Delta-8 on the premises' grounds or in the facility. -The residents knew the policy but some residents smoked Delta-8 just off the property grounds. -She did not know of any instance of Delta-8 use inside the facility. -The facility provided routine 2 hour supervision checks but could not provide one on one supervision of a resident due to staffing levels. -Any increased supervision (checks) would be on an individual basis and per an order from the resident's provider. -There were a couple of residents that would not comply with facility policy for sign-out that would have to be addressed individually. The guardians had been notified for individual instances and guidance for increased supervision. _____ The facility failed to provide supervision for 3 of 6 sampled residents (#2, #3 and #5) including a resident who had inappropriate sexual behaviors toward a female resident, and aggressive behaviors resulting in a male resident being physically assaulted, and left the facility without signing out (#3); a resident who left facility property without staff knowledge or supervision (#2); and a resident who was physically aggressive towards another resident resulting in the other resident being hit in the head with a cane (#5). This failure placed the residents at substantial risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/27/23 for this violation.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(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 39 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED November 26, 2023.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure residents were free of abuse, neglect and/or exploitation for 2 of 6 sampled residents (#1 and #12) related to a resident who experienced unwanted sexual advances from another resident (#1) and physical altercations with another resident (#12). The findings are: 1. Review of Resident #1's current FL2 dated 10/21/23 revealed: -Diagnoses of schizoaffective disorder, and diabetes. -She was intermittently disoriented. Review of Resident #1's Resident Register revealed an admission date of 08/02/23. Interview with a Resident #1 on 10/26/23 at 8:40am revealed: -A male resident had made unwanted sexual advances toward her.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 40	D 338		

-Once in September 2023, (unknown date), he pushed her down on the couch in the television room and got on top of her and made an inappropriate sexual comment.
-He tried to pull her into his room, touch her breasts and asked her to have sex on numerous occasions since she was admitted in August 2023.
-There were no witnesses and she did not tell staff in fear of retaliation from the male resident.
-She constantly wanted to get away from him and told her guardian she would like to be moved.
-Her guardian was aware of her accusations about the male resident.
-The only way to get away from the male resident was to be sent out to the hospital.
-She would act up towards staff to be sent out to get away from the male resident.
-She told the inpatient psychiatrist about the male resident's advances during her last hospital admission in early October 2023.

Telephone interview with Resident #1's guardian on 10/26/23 at 9:10am revealed:
-The resident told her about a male resident approaching her for sex on different occasions since her admission in August 2023.
-She did not report or inquire with the facility to investigate because Resident #1 was known to make up incidents involving sex, as she did at her last facility.
-She had spoken with hospital staff during Resident #1's admission in October 2023 and told the hospital staff she did not feel it needed to be reported to Adult Protective Services (APS) due to her history of making things up.
-If other residents had complained of the same behavior, she thought it might now be true.

Interview with Resident #1's primary care provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 41	D 338		

(PCP) on 10/27/23 at 11:35am revealed:
-She had no report of any resident receiving unwanted inappropriate sexual advances from another resident.
-If she had been told of any inappropriate behavior, she would have reported it to the Operations Manager (OM) or Administrator for investigation.

Telephone interview with Resident #1's Mental Health Provider (MHP) on 10/27/23 at 12:00am revealed he received no complaint from any current resident of inappropriate sexual behaviors.

Interview with a personal care aide (PCA) on 10/27/23 at 11:20am revealed:
-She had redirected the male resident out of female residents' rooms but she had not witnessed any inappropriate sexual behavior or touching.
-Some female residents told her they just tried to avoid being around the male resident because he made them feel uncomfortable.

Telephone interview with a Supervisor/ medication aide (S/MA) on 10/27/23 at 1:05pm revealed:
-She was not aware a male resident had pushed Resident #1 on the couch and got on top of her or that he pulled her into his room and touched her breasts.
She had found the male resident in female residents' rooms and made him come out.
-If she had known of any inappropriate touching or assault, she would have notified the Administrator, guardian and Department of Social Services (DSS) Supervisor.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 42	D 338		

(RCC) on 10/27/23 at 3:50pm revealed:
-She had not received any report of inappropriate sexual behavior from any resident.
-If she had, she would have notified local law enforcement, the Administrator, the guardian and DSS Supervisor so that the incident would be investigated.

Interview with the Operations Manager (OM) on 10/27/23 at 2:40pm revealed:
-He was not aware that any resident displayed inappropriate sexual or threatening behavior.
-If any resident made an accusation, the facility would investigate and notify the DSS Supervisor and follow any direction from them.
-The guardian or power of attorney would also be notified, and the resident would have the option to file a police report.
-The offender would have been subject to discharge from the facility.
-He was aware one resident had been a problem for the facility and bothered other residents, and was making an effort to get that resident discharged, immediately.

Interview with the Administrator on 10/27/23 at 2:45pm revealed:
-She was not aware of any inappropriate sexual behavior of any resident.
-There had been no APS investigation for any resident or incident.
-The facility would have initiated an investigation and required an immediate discharge of the offender.
-The resident who made an accusation would have had the opportunity to file a police report.

Refer to interview with the Operations Manager (OM) on 10/27/23 at 2:35pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 43 Refer to interview with the Administrator on 10/27/23 at 3:30pm. 2. Review of Resident #12's current FL2 dated 03/23/23 revealed included schizoaffective disorder, bipolar disorder, hypertension, obesity, sleep apnea, and chronic obstructive pulmonary disease. Review of Resident #12's incident report dated 10/19/23 revealed: -Another resident was hitting and kicking at Resident #12. -Mental health mobile crisis was called for the other resident. -Resident #12 stated he did not know what happened. Review of the other resident's progress note dated 10/19/23 revealed: -The resident was on the patio hitting and kicking Resident #12 who was also on the patio. The other resident could not be redirected. -Mental health mobile crisis had been called for the other resident. Interview with a resident on 10/26/23 at 11:55am revealed: -She witnessed Resident #12 being hit and kicked by another male resident on the patio last week, unknown date. -Staff witnessed the incident, but she did not think the staff did anything about it. -The other resident had frequent episodes of yelling at other residents for no reason, including her. Interview with Resident #12 on 10/26/23 at 4:00pm revealed: -Another resident hit him in the jaw and tried to	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 44	D 338		

push him off a bench on 10/19/23.
-The incident was unprovoked; the other resident "just came up and started."
-Staff separated the other resident from Resident #12.
-The incident was "upsetting and scary."
-He had no injuries from the 10/19/23 incident.
-The other resident had never tried to hit him prior to or since 10/19/23.

Interview with a personal care aide (PCA) on 10/27/23 at 11:10am revealed:
-She worked on 10/19/23 during the incident.
-Staff tried to deescalate the situation between the resident and the other residents.
-Resident #12 told staff that the other resident hit Resident #12 in the face.
-Residents told staff that the other resident kicked Resident #12.

Interview with a second PCA on 10/27/23 at 4:58pm revealed:
-The other resident got upset when he did not have cigarettes.
-When the other resident was out of cigarettes, he asked residents and staff for cigarettes.
-He had never witnessed the other resident hit another resident.

Telephone interview with a medication aide (MA) on 10/27/23 at 1:37pm revealed:
-The other resident got angry quickly if he did not have cigarettes.
-The other resident was normally redirectable.
-She had never seen the other resident hit another resident.

Interview with the Resident Care Coordinator (RCC) on 10/27/23 at 5:07pm revealed:
-She worked on 10/19/23 during Resident #12's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 45	D 338		

incident with another resident.
-A MA told her about the incident.
-She called mental health mobile crisis on 10/19/23 regarding the incident between Resident #12 and another resident, then left for the day.
-The other resident occasionally "acted up" but she felt that the residents were safe around him.

Interview with the Operations Manager (OM) on 10/27/23 at 2:40pm revealed he was not aware of the incidents involving Resident #12 on 10/19/23.

Interview with the Administrator on 10/27/23 at 2:45pm revealed she did not know about the incidents involving Resident #12 on 10/19/23.

Refer to interview with the Operations Manager (OM) on 10/27/23 at 2:35pm.

Refer to interview with the Administrator on 10/27/23 at 3:30pm.

_____

Interview with the OM on 10/27/23 at 2:35pm revealed:
-The facility's policy was to protect the health, safety and welfare of residents at all times.
-The staff were trained on the rights of residents and should be constantly protecting the residents' rights.

Interview with the Administrator on 10/27/23 at 3:30pm revealed staff, as well as she, had received training and were aware of the importance of ensuring all residents' rights were protected.

_____

The facility failed to keep residents free of physical and mental abuse by not intervening and protecting residents related to a resident who experienced inappropriate and unwanted sexual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 46 advances from a male resident resulting in the resident acting out towards staff to be sent to the hospital to get away from the male resident (#1) and a resident who was hit and kicked by another resident (#12). This failure placed residents at substantial risk of physical harm, abuse and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/26/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED November 26, 2023.	D 338		