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 _____	R-C 01/26/2024

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 (DSS) conducted a follow-up survey and complaint investigation from 01/24/24 through 01/26/24. The complaint investigation was initiated by the Yadkin County DSS on 01/19/24.	{D 000}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) including a resident who left the facility property without supervision and drank and smoked in his room (#2) and another resident who smoked in his room (#3) The findings are: 1. Review of the facility's undated Alcoholic Beverages Policy revealed: -Alcoholic beverages including beer, wine, and distilled spirits were not permitted in the facility	{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 _____	R-C 01/26/2024

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 1 except when prescribed by the physician. -In order to have alcoholic beverages in the facility the prescribing practitioner was to assess the resident's capacity to drink independently and write an order for the specific amounts of alcoholic beverage the resident was allowed to have in a 24-hour period. -The purchase of such beverages was at the expense of the resident or resident's family. -Storage and dispensing of such beverages were the responsibility of the community staff. -If a resident did not abide by the guidelines in the alcoholic beverage policy, the resident would be subject to discharge. Review of the facility's undated Sign Out/In Policy revealed: -In order to assure residents' health and well-being, staff needed to know where residents were at all times while in the facility's care. -Residents were to comply with the facility's sign out/in policy when leaving the facility for any reason and failure to comply would result in discharge from the facility. -Residents could leave the facility any time between the hours of 8:00am until 8:00pm. -All residents signed out for a nonscheduled activity such as walking into town, were required to be in the facility by 9:00pm. -The facility policy required staff to lock and alarm all doors at 9:00pm to assure the safety of all residents at night. -In order to leave the facility, residents were required to sign out and back in upon return using the sign out book. -All information requested must be filled in including the time of departure, expected time of return, location, resident or responsible person signing out, and the phone number of family or friend signing the resident out.	{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 _____	R-C 01/26/2024

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 2 Review of Resident #2's current FL2 dated 01/11/24 revealed: -Diagnoses included alcohol use disorder, history of schizoaffective disorder, hyponatremia, tachyarrhythmia, chronic obstructive pulmonary disorder exacerbation, and acute respiratory failure with hypoxia. -Resident # 2 was ambulatory and intermittently confused. Review of Resident #2's care plan dated 03/09/23 revealed: -He got along well with other residents and staff and was very friendly. -He had a history of substance abuse and mental illness, was administered medications for mental illness/behavior, and was receiving mental health services. -There was no documentation regarding behaviors. -There was documentation Resident #3 was to be monitored daily for safety. Review of Resident #2's physician's orders revealed there were no orders for alcoholic beverages. Review of Resident #2's psychotherapy progress note dated 12/04/23 and 12/11/23 revealed: -Resident #2 was not currently a danger to himself or others. -Treatment goals included decreasing alcohol consumption by 50% as indicated by the treatment team feedback and resident feedback. -Resident #2 had a goal to drink no more than 4 times a week. Review of Resident #2's psychiatry progress note dated 01/18/24 revealed:	{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 _____	R-C 01/26/2024

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 3 -Resident #2 had a history of alcohol dependence and there seemed to be intermittent alcohol use. -He was not currently taking any medications for alcohol use. -There were no recent withdrawal symptoms noted by staff or Resident #2. -Staff were to continue to monitor Resident #2 for alcohol use and withdrawal symptoms. Review of Resident #2's progress note dated 11/25/23 at 11:49pm revealed: -There was documentation that while doing 2-hour checks, staff noted that Resident #2 and his room smelled of alcohol. -The personal care aide (PCA) saw a large beer bottle sitting on the floor. -The PCA went to get the medication aide (MA) and then took the bottle and dumped the beer out. Review of Resident #2's progress note dated 11/29/23 at 11:49pm revealed Resident #2 had a very strong smell of alcohol. Review of Resident #2's progress note dated 01/09/24 at 12:28am revealed: -Staff found alcohol in Resident #2's room. -Resident #2 stated that the alcohol helped his heart condition and helped him not to have a heart attack every half hour. -Staff threw the alcohol away. Review of Resident #2's progress note dated 01/22/24 at 12:06am revealed: -Resident #2 was found drinking a beer in his room. -The beer was poured out and thrown away by staff. -Resident #2 got a little hateful towards staff after the beer was poured out.	{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 _____	R-C 01/26/2024

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 4 Review of the facility's sign out/in logs for November 2023 revealed: -Resident #2 did not sign out, sign in, or document his location on 11/03/23, 11/04/23, 11/06/23, 11/07/23, 11/08/23, 11/10/23, 11/11/23, 11/12/23, 11/13/23, 11/16/23, 11/17/23, 11/18/23, 11/22/23, 11/26/23, and 11/27/23. -Resident #2 signed out on 11/15/23, but he did not sign back in and did not document a location. -Resident #2 signed out on 11/01/23, 11/23/23, and 11/24/23 with his location, but he did not sign back in. -Resident #2 signed out and back in on 11/21/23, but he did not document his location. -Resident #2 did not sign out or document his location on 11/29/23, but he signed back in. -There were no sign out/in sheets for 11/02/23, 11/05/23, and 11/14/23. -Resident #2 signed out, signed in, and documented his location on 11/19/23, 11/20/23, 11/28/23, and 11/30/23. Review of the facility's sign out/in logs for December 2023 revealed: -Resident #2 did not sign out, sign in, or document his location on 12/01/23, 12/02/23, 12/03/24, 12/04/23, 12/05/23, 12/06/23, 12/10/23, 12/15/23, 12/16/23, 12/17/23, 12/19/23, 12/20/23, 12/21/23, 12/27/23, 12/28/23, 12/30/23, and 12/31/23. -Resident #2 documented his name on 12/18/23, but he did not sign in, sign out, or document his location. -Resident #2 signed out on 12/08/23, 12/11/23, 12/12/23, 12/13/23, 12/16/23, 12/23/23, and 12/25/23 with his location, but he did not sign back in. -Resident #2 signed out on 12/29/23, but he did not sign back in and did not document a location.	{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 _____	R-C 01/26/2024

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 5 -Resident #2 did not sign out or document his location on 12/26/23, but he signed back in. -Resident #2 signed out, signed in, and documented his location on 12/24/23. -There were no sign out/in sheets for 12/07/23, 12/09/23, 12/14/23, and 12/22/23. Review of the facilty's sign out/in logs for January 2024 revealed: -Resident #2 did not sign out, sign in, or document his location on 01/01/24, 01/09/24, 01/11/24, 01/13/24, 01/14/24, 01/16/24, 01/18/27, 01/20/24, 01/22/24, 01/24/24. -Resident #2 signed out on 01/02/24, 01/04/24, 01/08/24, 01/10/24, 01/15/24, 01/19/24, 01/21/24, and 01/23/24 with his location, but he did not sign back in. -Resident #2 signed out and back in on 01/03/24, but he did not document his location. -There were no sign out/in sheets for 01/07/24 and 01/17/24. Observation of Resident #2 on 01/24/24 at 9:30am revealed Resident #2 was laying on the concrete floor of the outside patio smoking area on his back, smoking a cigarette. Interview with the maintenance staff on 01/24/24 at 9:36am revealed: -Resident #2 left the facility often. -He had to pick Resident #2 up 4 to 5 times from the local gas station. Interview with the maintenance staff on 01/25/24 at 10:52am revealed: -Resident #2 was sitting on a bench outside the local gas station when he first got there on 01/24/24. -When he walked in the store, the store attendant was complaining about Resident #2 and saying	{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 _____	R-C 01/26/2024

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 6 that he needed to leave the property. -When he came back out of the gas station, Resident #2 was laying on the ground on his back between two gas pumps smoking a cigarette. -Resident #2 had been drinking. -He asked Resident #2 to open his book bag to make sure he did not have any alcohol in it. -Resident #2 had a container with alcohol and 2 empty bottles in his book bag. -Resident #2 got his beer from different stores across town. -Whenever Resident #2 drank, he stooped down to the ground wherever he was. -He picked Resident #2 up one day from behind a store after a customer told him he was behind the store; Resident #2 was stooped down behind the store. -When Resident #2 drank, he screamed at staff and residents. -He knew when Resident #2 had been drinking because he could smell the alcohol on him. Observation of Resident #2 on 01/25/24 at 1:37pm revealed: -Resident #2 was on the sidewalk of a main street. -There was a steady rain outside. -Resident #2 was squatting down on the sidewalk with his knees bent and his head bowed towards his knees. Observation of Resident #2 on 01/26/24 at 3:22pm revealed he was walking from a local gas station parking lot towards the facility. Interview with Resident #2 on 01/24/24 at 2:06pm revealed: -He left the facility when he felt like it and went to the library, a local church, a local gas station, and a local business.	{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 _____	R-C 01/26/2024

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 7 -He walked slow and took breaks. -The length of time that he was gone varied. -Sometimes he signed out and sometimes he did not sign out; sometimes he told staff where he was going, and sometimes he did not tell staff where he was going. -Lately he had been a little confused about how to get back to the facility, but he had not told anyone. -When he had the money to drink, he drank outside and in the woods. -He had not had alcohol in his room lately and he was not supposed to talk about it. -Staff told him he could not drink in his room. Interview with a PCA on 01/24/24 at 9:47am revealed: -Resident #2 left the facility daily and she did not know where he went when he left. -When Resident #2 left the facility he usually came back intoxicated and verbally aggressive. -When he was intoxicated staff tried to get him to calm down or to lay down to take a nap. Interview with a MA on 01/24/24 at 2:42pm revealed: -Resident #2 left the facility daily for extended amounts of time. -Staff had received phone calls from local businesses informing that he was on the business premises pan handling or drunk, and staff went to pick him up. -When Resident #2 left the facility, he usually signed out, but sometimes he did not. -He returned to the facility drunk almost every time after leaving. -He was belligerent, getting verbally aggressive with residents and staff after drinking, but he was not aggressive when he was not drinking. -If the staff suspected Resident #2 had alcohol on	{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 _____	R-C 01/26/2024

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 8	{D 270}		

him when he returned to the facility, they conducted a room sweep to look for it.
-She saw alcohol in Resident #2's room about 3 months ago.
-The last time she documented a progress note for Resident #2, about a week ago, she documented Resident #2 was laying in bed drunk and smoking.
-Resident #2 usually left the facility after breakfast and returned for lunch sometimes, but he usually came back around 2:00pm.
-He sometimes left back out of the facility after dinner and returned before third shift staff arrived.
-Previous shift staff left the facility at times and called back to the facility to let staff know Resident #2 was standing in someone's yard.

Interview with a second MA on 01/24/24 at 3:28pm revealed:
-Resident #2 was in and out of the facility all day and returned intoxicated more times than not.
-Sometimes he signed out when he left and sometimes, he did not.
-Staff did not know where he was going when he left the facility.
-Sometimes she passed him on her days off sitting on the side of the road on the ground.
-Resident #2 was usually verbally aggressive and cursed at staff and residents when he was intoxicated.
-Staff tried to keep an eye on him when he returned intoxicated and tried to check on him every 15 to 20 minutes, but there was no documentation of staff checking on him.
-She did not know of Resident #2 having any issues with confusion.

Telephone interview with a PCA/MA on 01/24/24 at 4:05pm revealed:
-Resident #2 left the facility every day, a couple

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 _____	R-C 01/26/2024

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 9 times a day. -He sometimes left the facility between 2:00pm and 3:00pm and did not come back until 9:00pm. -He forgot to sign out at times and just left the facility. -When he did sign out, he did not document where he was going. -Resident #2 sometimes came back to the facility intoxicated. -Staff checked on Resident #2 more frequently and may have held his medication depending on the severity of his intoxication. -Staff monitored Resident #2 more closely by knocking on his door and checking on him every time they passed his room, but there were no scheduled times for checking on Resident #2. -He thought there was a policy regarding no alcohol use in the facility. Interview with another PCA on 01/25/24 at 12:48pm revealed: -Resident #2 left the facility every day and he did not always sign himself out. -He did not always let staff know where he was going. -He came back to the facility 90% of the time intoxicated and she could tell because he walked to the side, slurred his speech, and he usually cursed and yelled after drinking. -Sometimes she saw Resident #2 around town laying on the side of the road on her days off. -She was concerned sometimes when Resident #2 was out of the facility; she was afraid that someone would hit him sitting or laying on the side of the road. -She got a call from a person in the neighborhood on 01/24/24 stating that she saw Resident #2 laying between the gas pumps smoking a cigarette at the local gas station; the maintenance staff went to pick him up.	{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 _____	R-C 01/26/2024

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 10	{D 270}		

-She tried to check on Resident #2 every 30 minutes when he was at the facility, but she had not been told to increase supervision for him.
-There was a form to document on when a resident was on increased safety checks of every 15-minutes, but Resident #2 had never been on 15-minute checks.

Telephone interview with a third shift PCA on 01/26/24 on 8:39am revealed:
-Her shift, which included third shift, started at 7:00pm.
-Resident #2 did not leave the facility during her shift when it was cold outside, but there were times when he did not come back to the facility until after she started her shift.
-There were times when Resident #2 came back to the facility as late as 1:00am or 2:00am, especially during the summer time.
-If Resident #2 stayed out late, sometimes the MA would have her go out to look for him.
-She had been concerned about Resident #2 being away from the facility late at night, because when he was away from the facility, he was usually drinking.
-It was too cold for him to be out late right now, so he brought alcohol back to the facility to consume.
-She had seen him walking down the street with a bottle of alcohol on her days off.
-She could tell when he had been drinking because she could smell the alcohol on him. and he got very confrontational with staff and residents when he drank.
-She had seen him with alcohol in the facility; sometimes staff were able to get the bottle from him to pour the alcohol out and sometimes he chugged the alcohol before staff could take it from him.
-She had not been told to increase supervision for

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 _____	R-C 01/26/2024

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 11 Resident #2 after finding him with alcohol or when he came back to the facility having drank alcohol. Interview with a third MA on 01/26/24 at 10:56am revealed: -Resident #2 was usually drunk when he came back from being out of the facility. -The facility staff instructed Resident #2 to check back in with facility staff every 2 hours, but he did not comply with the instructions to check in every 2 hours. -Staff went out to check to see where Resident #2 was if he was not back at the facility within 2 hours. -Staff did not check on Resident #2 more often than every 2 hours when he was in the facility. Interview with Resident #2's primary care provider (PCP) on 01/25/24 at 12:02pm revealed: -She was aware Resident #2 left the facility often without staff and that he did not always let staff know when or where he was going. -She sometimes saw him standing at the street, at a local gas station, on the sidewalk, and he sometimes laid in the facility's driveway. -She knew Resident #2 drank and came back to the facility intoxicated. -Resident #2 was aggressive every time she saw him; he got in her face and yelled at her. -She had concerns with Resident #2's alcohol use and smoking in the facility. -She was concerned with his safety and the safety of other residents and staff. -She expected staff to provide increased supervision greater than every 2 hours when he was at the facility. Telephone interview with Resident #2's mental health provider (MHP) on 01/25/24 at 2:56pm revealed:	{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 _____	R-C 01/26/2024

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 12 -She started seeing Resident #2 in November 2023. -She was aware Resident #2 left the facility often without staff supervision. -Resident #2 did not have an issue with his cognition, but his judgement was not the best. -She would recommend having someone go with Resident #2 when he left the facility. -She aware of Resident #2 consuming alcohol when he left the facility and asked facility staff if they monitored his alcohol use, but they just went by what Resident #2 told them. -Staff told her Resident #2 consumed 1 to 2 beers a day. -She told staff to hold certain medications if they suspected Resident #2 to be intoxicated. -She did not know staff found alcohol in Resident #2's room. -She had a general concern for Resident #2 and the safety of other residents. Telephone interview with Resident #2's guardian on 01/26/24 at 9:34am revealed: -He knew Resident #2 left the facility often by himself. -He was not "okay" with Resident #2 leaving the facility and had shared his concerns with the facility staff. -Resident #2 was a prolific alcoholic and wandered throughout the community, went to local stores, and panhandled for cigarettes, snacks, and alcohol when out of the facility. -There had been discussions with the facility's management about the facility having limited ability to keep Resident #2 on the premises, challenges with Resident #2 being intoxicated, Resident #2 yelling and screaming at staff and other residents, and Resident #2 staying up late hours throughout the night. -There had been discussions with the facility's	{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 _____	R-C 01/26/2024

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 13 management since the summer of 2023 about possibly moving Resident #2 to a sister facility; the Administrator felt that the current facility was able to manage Resident #2. -He had not been notified Resident #2 was bringing alcohol into the facility. -He absolutely had concerns with Resident #2 not following facility protocols and him not being notified of Resident #2's incidents like drinking in his room. -Resident #2 had placement in other facilities and programs in the past, but he ended up leaving the facility on his own or being terminated from the program. -Finding placement for Resident #2 was difficult, but he needed to be in a place where he could be monitored better. Interview with the Administrator on 01/26/24 at 12:08pm revealed: -She knew Resident #2 left the facility every day and was sometimes gone for a lot of the day. -Sometimes when Resident #2 did not sign out of the facility, staff tried to go find him. -If staff were not able to locate Resident #2, they should have completed a missing person's report. -There had not been any need to complete a missing person's report for Resident #2 to her knowledge. -When Resident #2 came back to the facility drunk, staff were to inform his guardian, PCP, and MHP due to possible medication interactions. -She did not know Resident #2 was bringing alcohol back into the facility and expected staff to confiscate it if they saw it. -She expected that staff increased supervision for Resident #2 to 15-minute checks ongoing until the situation was resolved. 2. Review of the facility's undated smoking policy	{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 _____	R-C 01/26/2024

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 14 revealed: -The purpose of the smoking policy was to ensure that no resident smoked in the facility and that all residents were safe. -If a resident was caught smoking in the facility all smoking materials were taken from the resident immediately. -The first time a resident was caught smoking in the facility, the resident would not be able to keep any smoking materials for 7 days and would only be allowed to smoke with staff supervision; the resident would also be charged a fine of $3.00 to be deducted from the resident's monthly payout and donated to the local fire department. -The second time a resident was caught smoking inside the facility, the resident would not be able to keep any smoking materials for 14 days and would only be able to smoke with staff supervision.; the resident would also be charged a fine of $6.00 to be deducted from the resident's monthly payout and donated to the local fire department. -The third time a resident was caught smoking in the facility, the resident would not be able to keep any smoking materials for 30 days and would only be allowed to smoke with staff supervision; the resident would also be charged a fine of $12.00 to be deducted from the resident's monthly payout and donated to the local fire department. -In additional to smoking restrictions and monetary fines, the resident may also be given a notice to leave the facility for smoking in the facility. a. Review of Resident #2's current FL2 dated 01/11/24 revealed: -Diagnoses included alcohol use disorder, history of schizoaffective disorder, hyponatremia, tachyarrhythmia, chronic obstructive pulmonary disorder exacerbation, and acute respiratory	{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 _____	R-C 01/26/2024

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 failure with hypoxia. -Resident # 2 was ambulatory and intermittently confused. Review of Resident #2's progress note dated 11/19/23 at 2:26am revealed: -Resident #2 was smoking in his room for the second time tonight. -Resident #2 was asked not to smoke inside and the MA was informed. Review of Resident #2's progress note dated 12/15/23 at 6:18am revealed: -Resident #2 was caught smoking in his room. -When the personal care aide (PCA) told him to stop, he began calling the PCA names. Review of Resident #2's progress note dated 01/16/24 at 10:40am revealed: -Resident #2 was caught smoking in his room. -When asked to put the cigarette out, Resident #2 began yelling and stating that he was having a heart attack. -Staff attempted to retrieve the cigarette from Resident #2 and he began attempting to kick the staff. -Resident #2 eventually threw the lit cigarette across the room. -Staff retrieved the lit cigarette and extinguished it. Observation of Resident #2's room on 01/24/24 at 2:04pm revealed: -There were 4 loose cigarettes on the floor and three of them had previously been smoked. -There were multiple cigarette butts on the floor. -There were two cigarette cartons on Resident #2's bed; one carton had only a lighter in it and the other carton had cigarettes and a second lighter.	{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 _____	R-C 01/26/2024

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 -There was a homemade pipe sitting on Resident #2's dresser and a homemade pipe sitting on a book under a chair in his room. -Both pipes were made of aluminum foil and had what appeared to be tobacco stuffed in one end. Interview with Resident #2 on 01/24/24 at 2:06pm revealed: -He picked up the cigarette butts from the smoking area, took the tobacco out of the butts, and stuffed the tobacco into his homemade aluminum foil pipes to smoke. -Staff told him he could not smoke in his room, but they had not told him he could not have cigarettes or lighters in his room. -He did not want to talk about smoking in his room. Interview with a medication aide (MA) on 01/24/24 at 2:42pm revealed: -Resident #2 smoked in his room multiple times a week, usually when he had been drinking. -The last time she documented a progress note for Resident #2, about a week ago, she documented Resident #2 was laying in bed drunk and smoking. -Staff kept residents' cigarettes in the medication room and distributed a pack of cigarettes a day and residents were to buy their own lighters. -Some residents walked to the store and purchased their own cigarettes to keep in their room. -Residents were not supposed to smoke in their rooms, but Resident #2 was not on any smoking restrictions. -Management was aware Resident #2s smoked in his room. Interview with a second MA on 01/24/24 at 3:28pm revealed:	{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 _____	R-C 01/26/2024

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 -Resident #2 smoked in his room, mostly at night. -Staff smelled the smoke and went in to check on him and to get the cigarette. -Staff tried to keep an eye on him, but he got mad when staff went back and forth to his room. -Staff tried to check on him every 15 to 20 minutes, but there was no documentation of staff checking on him frequently. -Resident #2 was not on smoking restrictions to her knowledge. Observation of the facility on 01/24/24 between 3:30pm and 3:45pm revealed: -Resident #2 was laying on the floor, on his back, by the rear hallway door and he was smoking. -There was no staff present. Interview with Resident #2 on 01/24/24 at 3:46 revealed: -It was too cold outside to go out to smoke. -He was smoking his cigarette inside the facility because if he went outside in the cold, he would have a heart attack. Telephone interview with a PCA/MA on 01/24/24 at 4:05pm revealed: -He caught Resident #2 smoking in his room. -Resident #2 was usually found smoking by staff when they walk down the hall and smelled the smoke or other residents came and told staff Resident #2 was smoking in his room. -Resident #2 had also walked down the hall smoking. -Smoking in the facility had been an ongoing issue with Resident #2 and all staff were aware of him smoking in the facility. -He was concerned that Resident #2 may fall asleep with a cigarette in his hands and set himself or the facility on fire. -There were residents in the facility who used	{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 _____	R-C 01/26/2024

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}		

oxygen and there was a facility rule that residents could not smoke anywhere in the facility.
-When he caught Resident #2 smoking in the facility, his routine checks went from every 2 hours to every hour, and then to every 30 minutes, but he was not on smoking restrictions.
-Staff usually documented in Resident #2's progress notes that staff monitored the resident throughout the night.
-Only 15-minute checks were documented at intervals throughout the day, but Resident #2 had never been on 15-minute checks when he was in the facility.

Telephone interview with the PCA on 01/26/24 on 8:39am revealed:
-She documented Resident #2's progress notes dated 11/19/23 at 2:26am and 12/08/23 at 3:31am.
-Resident #2 smoked in his room daily and his room smelled like an ashtray.
-He was just smoking in his room last night, 01/25/24.
-Usually Resident #2 put the cigarette out on the floor when asked to stop smoking, and then he lit it back up once staff left the room.
-She told the MA on duty when she observed Resident #2 smoking in his room and management knew that he smoked in his room.
-She was not told to increase supervision of Resident #2 due to him smoking in his room.

Interview with a MA on 01/26/24 at 10:56am revealed:
-Resident #2 smoked in his room daily.
-Facility staff did not give Resident #2 cigarettes; he got them when he went out of the facility and from other residents.
-She was concerned with Resident #2 smoking in the facility because there were other residents in

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 _____	R-C 01/26/2024

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	{D 270}		

the facility with oxygen.
-She was also concerned about Resident #2 falling asleep and having a lit cigarette in his hand.
-She had talked to management about Resident #2 smoking in his room and kept reminding Resident #2 that smoking in his room was a safety concern.
-There was no increase in supervision for Resident #2 with him smoking in his room because he was not usually at the facility.

Interview with the maintenance staff on 01/25/24 at 10:52am revealed:
-He had not seen Resident #2 smoke in the facility, but he had found cigarette butts in his bathroom.
-He took Resident #2's trash can out of his room because he started burning paper in his trash can and burned the bottom of the plastic trash can.

Interview with Resident #2's primary care provider (PCP) on 01/25/24 at 12:02pm revealed:
-The facility had a protocol for no smoking in resident rooms and there were designated areas for smoking.
-She had concerns about Resident #2 smoking in his room.
-Staff tried to advise him not to smoke, but he smoked anyway.
-She was concerned with his safety and the safety of other residents and staff.
-She expected staff to provide increased supervision greater than every 2 hours.

Interview with Resident #2's mental health provider (MHP) on 01/25/25 at 2:56pm revealed:
-She did not know Resident #2 was smoking in his room.
-She expected staff to increase supervision in 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 _____	R-C 01/26/2024

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 facility if Resident #2 was smoking. -She had a general concern for Resident #2 and the safety of other residents. Telephone interview with Resident #2's guardian on 01/26/24 at 9:34am revealed: -He knew Resident #2 smoked and panhandled for cigarettes, but he did not know Resident #2 was smoking in the facility. -Facility staff also had not been notified Resident #2 was laying between gas pumps smoking on 01/21/24. -Smoking in the facility was against the facility's rules. -He absolutely had concerns with Resident #2 not following facility protocols and him not being notified of Resident #2's incidents. -Resident #2 had placement in other facilities and programs, but he ended up leaving the facility on his own or being terminated from the program. -Finding placement for Resident #2 was difficult, but he needed to be in a place where he could be monitored better. Interview with the Administrator on 01/26/24 at 12:08pm revealed: -She did not know Resident #2 was smoking in his room. -She expected staff to report Resident #2 smoking in his room to the Resident Care Coordinator (RCC) and the Campus Director (CD), ask Resident #2 to stop smoking in his room, and to redirect Resident #2. -She was concerned that Resident #2 smoking in the facility could endanger others. -She expected that staff increased supervision for Resident #2 to 15-minute checks ongoing until the situation was resolved. b. Review of Resident #3's current FL2 dated	{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 _____	R-C 01/26/2024

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 03/09/23 revealed: -Diagnoses included hypertension, schizophrenia, and vascular dementia. -Resident #3 was ambulatory and intermittently disoriented. Review of Resident #3's progress note dated 11/11/23 at 6:22am revealed: -Resident #3 was smoking a cigarette in his room while laying down. -Resident #3 was told that it was not okay to smoke in the facility. -The MA was informed of him smoking. -There was no documentation staff increased supervision for Resident #3 after he was found smoking in his room. Review of Resident #3's progress note dated 11/19/23 at 12:59am revealed: -Resident #3 was seem smoking a cigarette in his room. -His room was full of smoke. -Staff asked him to go outside if he wanted to smoke. -The MA was informed of him smoking. -There was no documentation staff increased supervision for Resident #3 after he was found smoking in his room. Review of Resident #3's progress note dated 12/02/23 at 11:00pm revealed: -Resident #3 was caught smoking in his room and the MA was informed. -There was no documentation staff increased supervision for Resident #3 after he was found smoking in his room. Telephone interview with the PCA on 01/26/24 on 8:39am revealed: -She documented Resident #3's progress notes	{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 _____	R-C 01/26/2024

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}		

on 11/19/23 at 12:59am and on 12/02/23.
-Resident #3 smoked in his room often and put the cigarettes out on the floor.
-PCAs were not allowed to document progress notes anymore, so now she just told the MA about him smoking in his room.
-She was told by management to ask Resident #3 to put his cigarette out and tell him not to smoke in his room anymore.
-She was not told to increase supervision for Resident #3 due to him smoking in his room.
-The smoking policy had not been implemented for Resident #3.

Interview with a MA on 01/26/24 at 10:56am revealed:
-Resident #3 had been caught a few times smoking in his room.
-Residents who were caught smoking in their rooms, were placed on smoking restrictions of 1 cigarette per hour and staff was to supervise smoking for 2 weeks.
-If the resident smoked in their room again, they were placed on smoking restrictions for 1 month and staff was to supervise smoking.
-If the resident smoked in their room a third time, they were placed on smoking restrictions and staff was to supervise smoking indefinitely.
-Resident #3 was not on smoking restrictions currently and she did not know why.
-There had not been an increase in supervision for Resident #3.

Interview with Resident #3's responsible party on 01/25/24 at 10:55am revealed:
-She was not aware Resident #3 had been smoking in his room.
-She did not feel staff communicated with her as they should.
-She did not know if Resident #3's primary care

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 _____	R-C 01/26/2024

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 provider (PCP) or mental health provider (MHP) had been contacted regarding him smoking in his room. -Staff had not talked to her about increasing supervision for Resident #3. Interview with Resident #3's MHP on 01/25/25 at 2:56pm revealed: -She was not aware Resident #3 was smoking in his room and disapproved of him smoking in his room. -She expected staff to check on Resident #3 more often than every 2 hours with him smoking in his room. -She had a general concern for Resident #3 and the safety of other residents. Interview with the Administrator on 01/26/24 at 12:08pm revealed: -She was not aware Resident #3 was smoking in his room. -Resident #3 should have been on restrictions according to the policy if he was smoking in his room. -Resident #3 should have also had increased safety checks due to smoking in his room. -Staff were aware of the facility's policy regarding residents smoking in the facility. _____ The facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) including a resident who had a diagnosis of alcohol use disorder and left the facility daily without staff knowledge or supervision, came back to the facility intoxicated, and drank and smoked in his room (#2); and a resident who had diagnoses of schizophrenia and vascular dementia and smoked in his room (#3). This failure placed the residents at substantial risk for physical harm and neglect which constitutes an unabated Type A2	{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 _____	R-C 01/26/2024

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 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-D-34 on 01/25/24 for this violation.	{D 270}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#3) related to failing to notify the resident's mental health provider (MHP) after the resident exhibited multiple aggressive behaviors and inappropriate interactions with female residents. The findings are: Review of Resident #3's current FL2 dated 03/09/23 revealed: -Diagnoses included hypertension, schizophrenia, and vascular dementia. -Resident #3 was ambulatory and intermittently disoriented. -There was no documentation of any inappropriate behaviors. a. Review of Resident #3's care plan dated 06/12/23 revealed: -Resident #3 was usually calm, but he tended to	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 25	D 273		

get a little agitated when he ran out of cigarettes.
-Resident #3 socialized with other residents when he was outside.
-Resident #3 had a history of mental illness, was administered medications for mental illness/behavior, and was receiving mental health services.
-There was no information documented regarding behaviors.
-There was documentation Resident #3 was to be monitored daily for safety.

Review of Resident #3's mental health provider's (MHP) progress notes dated 12/14/23, 12/28/23 and, 01/11/24 revealed:
-Resident #3's diagnosis of paranoid schizophrenia was chronic and complicated with vascular dementia and associated with anxiety.
-Staff reported no issues at this time.
-She would continue to monitor for changes in cognition and behavior.
-There was no documentation regarding any issues with behavior.

Review of Resident #3's psychotherapy progress notes dated 11/20/23 revealed:
-Resident #3 was not currently a danger to himself or others
-Treatment goals included decreasing inappropriate behavior by 50% as indicated by treatment team feedback, and resident feedback.
-Resident #3 was to engage appropriately with staff and peers and was to have verbal physical, and sexual outbursts no more than quarterly.

Review of Resident #3's psychotherapy progress note dated 12/04/23 revealed:
-Resident #3 was not currently a danger to himself or others
-Presenting symptoms included anger, delusions,

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 _____	R-C 01/26/2024

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 273	Continued From page 26	D 273		

and yelling.
-Treatment goals included decreasing inappropriate behavior by 50% as indicated by treatment team feedback, and resident feedback.
-Resident #3 was to engage appropriately with staff and peers and was to have verbal physical, and sexual outbursts no more than quarterly.

Review of Resident #3's progress note dated 10/28/23 at 6:03pm revealed:
-Another resident came to staff stating that Resident #3 was in a physical altercation with another resident.
-When asked, Resident #3 stated that the other resident had his clothes on.
-Upon evaluation, the other resident had his own clothing on.
-Staff attempted to calm Resident #3 down without success.
-Mobile Crisis was contacted and once they arrived, Resident #3 became belligerent with them.
-Mobile Crisis got Resident #3 to take medication and instructed the medication aide (MA) to call back if Resident #3 became irate again.
-There was no documentation Resident #3's MHP was notified.

Interview with Resident Care Coordinator (RCC) on 01/26/24 at 10:56am revealed:
-She documented Resident #3's progress note dated 10/28/23 at 6:03pm.
-Resident #3 thought his roommate had some of his clothes on, but he did not.
-Another resident came and got her and told her that Resident #3 was in a physical altercation with his roommate.
-When she got to the room, Resident #3 was standing in the room by his bed yelling at his roommate.

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 _____	R-C 01/26/2024

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 273	Continued From page 27 -She did not know if Resident #3 hit his roommate. -She separated the two residents and sent Resident #3's roommate outside. -She could not remember if she notified Resident #3's MHP provider about the incident. Review of Resident #3's progress note dated 11/08/23 at 6:29pm revealed: -Resident #3 was coughing at the dinner table and did not cover his mouth. -He was coughing towards another resident's face which caused the two residents to get up and get in each other's face. -Staff stepped in and had Resident #3 to go outside. -There was no documentation Resident #3's MHP was notified. Interview with a personal care aide (PCA) on 01/25/24 at 9:52am revealed: -She documented the progress note dated 11/08/23 at 6:29pm. -She heard noise coming from the dining room and when she arrived, she saw Resident #3 standing in front of another resident with his fists balled up. -Another staff got in between the two residents. -She told the MA on duty, but she did not know if the MHP was notified. Review of Resident #3's progress note dated 11/19/23 at 8:58pm revealed: -Resident #3 grabbed a female resident and shoved her out of the way; a male resident stepped in and helped the female resident. -Resident #3 yelled at staff. -There was no documentation Resident #3's MHP was contacted.	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 28 Telephone interview with a PCA on 01/26/24 at 8:39am revealed: -She documented Resident #3's progress note dated 11/19/23 at 8:58pm. -On 11/19/23, Resident #3 was sitting outside in the smoking area in front of the heater. -A female resident was standing beside him and he did not want her there. -Resident #3 grabbed the female resident by the shoulder and tossed her to the side. -A male resident stepped in to help the female resident and told her about it after it happened. -There was also a time in the dining room, a few months ago during snack time, when Resident #3 was in verbal altercations with another residents; when she asked him to leave the dining room, he threw 3 cups of ice water on her. -She told the MA on duty about the incidents, but she did not know who was responsible for reaching out to Resident #3's MHP. Review of Resident #3's progress note dated 12/10/23 at 4:02pm revealed: -On 12/10/23 at 12:09pm, Resident #3 was involved in a verbal altercation with another resident. -The verbal altercation developed further into a physical altercation in which the resident pushed another resident to the ground. -Staff separated the two residents and the police department was called. -There was no documentation Resident #3's MHP was notified. Interview with a PCA/MA on 01/25/23 at 3:40pm revealed: -He documented Resident #3's progress note dated 12/10/23 at 4:02pm and had witnessed the altercation between Resident #3 and another resident.	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 29	D 273		

-On 12/10/23, he was in the dining hall when he heard Resident #3 and the other resident yelling at each other.
-He did not hear what Resident #3 and the other resident were arguing about, but he saw Resident #3 turn to face the other resident and then the other resident fell backwards to the floor.
-As the other resident was falling to the floor, he tried to brace himself with his hands.
-After the altercation on 12/10/23, the other resident was diagnosed with a right wrist fracture.
-He did not notify Resident #3's MHP about the incident.
-Whoever the MA was during the incident was responsible for reporting behaviors to the MHP.
-He did not know if Resident #3's MHP was aware of any of his behaviors.

Review of Resident #3's progress note dated 12/10/23 at 5:14pm revealed:
-Resident #3 started flipping out in the hall and then hit another resident knocking the other resident on the floor.
-Resident #3 then started fussing at everyone and breaking stuff.
-The police and mobile crisis were called, but nothing was done.

Interview with a MA on 01/25/24 at 12:50pm revealed:
-She documented Resident #3's progress note dated 12/10/23 at 5:14pm.
-On 12/10/23, Resident #3 was ranting and raving as usual.
-Resident #3 was in the hallway calling an older female resident vulgar names and another resident told Resident #3, "You don't have to talk to her like that."
-Resident #3 turned around and shoved the other resident to the floor.

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 _____	R-C 01/26/2024

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 273	Continued From page 30 -The other resident fell backwards and slid down the hallway on his back. -Another MA sent the other resident to the urgent care on 12/11/23 where he was diagnosed with a right wrist fracture. -She called the police, mobile crisis, Resident #3's responsible party and Resident #3's MHP; there should have been documentation of who she contacted in Resident #3's progress notes. -There were no supervisors in the facility at the time of the altercation, so she called the Operation's Manager (OM) to notify her about the incident. Review of Resident #3's progress note dated 01/21/24 at 6:29am revealed: -Resident #3 was involved in a verbal altercation that ended up in a physical altercation between himself and another resident in the dining room. -Resident #3 attempted to stab the other resident with his fork. -A PCA stepped between the two residents and tried to remove the fork from Resident #3. -When the fork was removed, the residents were separated. -There was no documentation Resident #3's MHP was notified. Interview with the same PCA/MA on 01/25/24 3:40pm revealed: -He documented Resident #3's progress note dated 01/21/24 at 6:29am. -On 01/21/24, he was in the dining room passing meal trays when a resident asked Resident #3 to cover his mouth while he was coughing. -Resident #3 became angry at the other resident and started yelling and cussing at him. -Resident #3 drew back his hand wielding a fork and looked like he was threatening to stab the other resident with it.	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 31	D 273		

-He immediately stepped between the two residents and took the fork from Resident #3's hand.
-He asked Resident #3 to sit down at his seat and there were no further altercations between the two residents.
-The PCA/MA was nicked by the fork, but he did not know whether he was nicked as a result of Resident #3 coming down with the fork or a result of him brushing his hand up against the fork being held by Resident #3.
-The other resident was not injured during the altercation.
-He did not notify the Resident #3's MHP about the incident.
-Whoever the MA was during the incident was responsible for reporting behaviors to the MHP.
-He did not know if Resident #3's MHP was aware of any of his behaviors.

Review of Resident #3's progress notes revealed:
-On 11/29/23 at 1:20pm, Resident #3 was in verbal altercations multiple times with staff and other residents.
-On 11/29/23 at 2:05pm, Resident #3 had been yelling and using foul language towards other residents and staff.
-On 12/03/23 at 1:55am, Resident #3 had been yelling and screaming at all staff due to him not having cigarettes.
-On 12/24/23 at 4:25pm, Resident #3 was involved in a verbal altercation with another resident over a place to sit during the 3:30pm snack; the residents were separated and asked to leave the dining room.
-On 01/07/24 at 1:05am, Resident #3 was on the 300 hall sitting in a vacant wheelchair at 12:07am and a PCA asked him to go back to the 200 hall; Resident #3 cursed the PCA and refused to get up and leave; Resident #3 got up and threw a cup

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 _____	R-C 01/26/2024

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 273	Continued From page 32	D 273		

full of water splashing it all over the place and the PCA; Resident #3 walked off the hall and kept returning throughout the night.

Interview with a resident on 01/25/24 at 9:40am revealed:
-A few weeks ago, he was sitting at a picnic table in the outside patio smoking area and Resident #3 was standing in a corner.
-Resident #3 just came up to him and hit him on the right side of his face in the temple area and walked away; his head still hurt.
-Resident #3 also punched him in his right jaw in the cafeteria, but he did not remember when.
-He had seen Resident #3 hit a couple other residents, but he did not remember the residents' names.
-He felt like he could not let his guard down when Resident #3 was around because Resident #3 might hit or hurt him.
-He was afraid of Resident #3, but he had not told staff that he was afraid.

Interview with a second PCA on 01/25/24 at 9:52am revealed:
-Resident #3 got into verbal and physical altercations with other residents and did not remember any altercations 10 minutes later.
-Resident #3 initiated altercations and staff tried to redirect him.
-She reported any altercations to the MA on duty that day and the MAs were responsible for following up with the resident's MHP.

Interview with Resident #3's responsible party on 01/25/24 at 10:55am revealed:
-The facility staff notified her of when Resident #3 pushed another resident down and that he threw a glass of water at someone a few months ago.
-She did not know about Resident #3 trying to

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 _____	R-C 01/26/2024

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 273	Continued From page 33	D 273		

stab another resident with a fork on 01/21/24.
-Resident #3 had aggressive behaviors when he did not take his medication properly and staff did not tell her when he did not take his medication.
-She did not know if Resident #3's primary care provider (PCP) or MHP had been contacted regarding his behaviors.

Interview with Resident #3's PCP on 01/25/24 at 12:02pm revealed:
-Staff told her about Resident #3's physical aggression.
-Resident #3 was forgetful of what he did.
-Staff told her about the instance where Resident #2 pushed another resident causing the other resident to fracture his arm, but she did not know about Resident #3 trying to stab another resident with a fork.
-She would have expected to be notified about Resident #3 trying to stab the other resident with a fork.
-She was concerned Resident #3 would be a danger to other residents and talked to staff in December 2023 about the possibility of placement in a different facility.
-She had not talked to staff about increasing his safety checks.

Interview with Resident #3's MHP on 01/25/25 at 2:56pm revealed:
-She started seeing Resident #3 on 11/16/23 and had seen him twice.
-She was not aware of Resident #3 having any behavior issues including physical aggression.
-She expected the facility to contact her or let her know during her scheduled visits to the facility that Resident #3 was having physical aggression with other residents.
-Had she known, she would have reviewed his medications to see if any needed to be adjusted,

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 _____	R-C 01/26/2024

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 273	Continued From page 34	D 273		

and recommended more safety precautions and additional supervision when around other people.

Interview with the Administrator on 01/26/24 at 12:08pm revealed:
-She knew about Resident #3 having a physical altercation with another resident in which resulted in the other resident having a fractured wrist.
-She did not know about Resident #3 trying to stab another resident in the dining hall.
-If Resident #3 exhibited aggressive behaviors, she expected staff to intervene, deescalate, and report the behaviors to the RCC.
-She and the Campus Director (CD) talked about a possible change of care for Resident #3 a few months ago.
-She did not know if the MHP was aware of Resident #3's inappropriate behaviors.
-She expected the RCC to report behavior issues to Resident #3's MHP and psychotherapist, and for staff to increase safety checks based on the situation.

Interview with the RCC on 01/26/24 at 1:16pm revealed:
-Staff used the facility provider's triage system to text and send messages to the PCP and the MHP
-She or any MA could use the triage system to notify the PCP or the MHP of any issues.
-She thought the MHP was contacted after Resident #3 pushed the resident down resulting in the other resident sustaining a fractured wrist, but she did not know if the MHP was contacted after all of Resident #3's aggressive behaviors.

Resident #3 was unavailable to be interviewed on 01/25/24 at 11:06am.

Attempted telephone interview with the Operations Manager (OM) on 01/26/24 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 _____	R-C 01/26/2024

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 273	Continued From page 35 11:40pm was unsuccessful. Attempted telephone interview with Resident #3's psychotherapist on 01/26/24 at 1:22pm was unsuccessful. b. Review of Resident #3's progress note dated 11/19/23 at 1:16am revealed Resident #3 went into a few females' rooms without being invited. Review of Resident #3's progress note dated 11/19/23 at 3:01am revealed: -Resident #3 was hanging around the medication room all evening asking for cigarettes and food, and when the MA told him there was nothing to give him, Resident #3 cursed the MA and called her a "whore like the rest of them." -By 11:00pm, Resident #3 was asked to go to his hall, and he became angry and threatened the MA and a female PCA; a male PCA intervened and Resident #3 went to his hall. -Not long after Resident #3 went to his hall, he was caught in a female resident's room uninvited and was told to leave. -Resident #3 had also been in another female resident's room earlier. -There was no documentation Resident #3's MHP was contacted. Review of Resident #3's progress note dated 11/20/23 at 3:33pm revealed: -Resident #3 was being inappropriate with female residents. -He believed he was married to all the female residents. -Resident #3 was being confrontational with all the other residents and staff. -Mobile Crisis was called. -There was no documentation Resident #3's MHP was contacted.	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 36 Review of Resident #3's progress note dated 11/20/23 at 3:52pm revealed: -Mobile Crisis came to the facility to see Resident #3 and petition for an involuntary commitment for Resident #3. -Resident #3's guardian was contacted. -There was no documentation Resident #3's MHP was contacted. Interview with a resident on 01/25/24 at 10:10am revealed: -Last month, Resident #3 kept telling her he wanted to date her, but she did not want to date him. -He came in her room one night and started yelling at her about going outside and she told him no. -He kept telling her he wanted her to marry him. Interview with a second resident on 01/25/24 at 11:24am revealed: -Resident #3 came into her room with his pants down and shut the door behind him. -His pants were already down before he came in her room. -Resident #3 did not say or do anything to her, but just stood there looking at her. -Staff did not come in her room to get him, she got out of the bed, and walked past Resident #3 to go get staff to get him out of her room. Interview with a third resident on 01/25/24 at 4:06pm revealed: -She was in the bed asleep when she woke up to Resident #3 standing inside her bedroom doorway with his shirt unbutton. -Resident #3 was standing there looking at her, but he did not say anything or do anything to her. -She told Resident #3 to leave her room and he	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 37	D 273		

left, but she did not know how long he had been standing in her room before she woke up.
-She thought Resident #3 came into her room about 6 months ago.
-Sometimes when she was sitting at a table in the outside patio smoking area, Resident #3 bent over and looked under the table at her private parts and had also stared at her breasts.
-She told staff about Resident #3 coming in her room and looking at her in the outside smoking area, but she did not know if anything was done.

Interview with Resident #3's responsible party on 01/25/24 at 10:55am revealed:
-Facility staff called her a few months ago to let her know Resident #3 had been inappropriate with female residents.
-Staff told her Resident #3 was talking inappropriately to some of the residents and exposed himself.
-Resident #3's doctor put him on a medication to help with his sexual desire previously, but she did not remember when.
-Resident #3 had inappropriate behaviors with female residents at a different facility about 2 years ago.
-She did not know if Resident #3's PCP or MHP had been contacted regarding his behaviors.

Interview with Resident #3's PCP on 01/25/24 at 12:02pm revealed she expected any inappropriate behaviors with female residents to be reported to the Resident #3's MHP.

Interview with Resident #3's MHP on 01/25/25 at 2:56pm revealed:
-She was not aware of Resident #3 having inappropriate behaviors with female residents and she expected to be notified.
-Had she known, she would have reviewed

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 _____	R-C 01/26/2024

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 273	Continued From page 38	D 273		

Resident #3's medications to see if any needed to be adjusted, and recommended more safety precautions and additional supervision when around other people.

Interview with the Administrator on 01/26/24 at 12:08pm revealed:
-She knew about instances of Resident #3 having inappropriate behaviors with female residents.
-She thought Resident #3's diagnosis of dementia played a role in his inappropriate behaviors.
-She and the Campus Director (CD) talked about a possible change of care for Resident #3 a few months ago.
-She did not know if the MHP was aware of Resident #3's inappropriate behaviors.
-She expected the RCC to report behavior issues to Resident #3's MHP and psychotherapist, and for staff to increase safety checks based on the situation.

Interview with the CD on 01/26/24 at 12:45pm revealed:
-He was aware of one instance when Resident #3 had gone into a female resident's room uninvited, but no others.
-He had the Activities Director to speak to the female resident on that occasion and the female resident did not have any concerns and did not feel threatened by Resident #3.
-He would have expected staff to contact Resident #3's MHP and PCP.
-There was a recent change in the facility's MHP, so he thought staff may have been reporting behaviors to the previous MHP.

Interview with the RCC on 01/26/24 at 1:16pm revealed:
-Staff used the facility provider's triage system to text and send messages to the PCP and the MHP

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 _____	R-C 01/26/2024

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 273	Continued From page 39 -She or any MA could use the triage system to notify the PCP or the MHP of any issues. -She did not know if the MHP was contacted after Resident #3 was found going into female residents' rooms. -She was not aware of Resident #3's goals in the psychotherapist notes to decrease sexual outbursts; the Operations Manager was responsible for reviewing the psychotherapist notes. -Resident #3's psychotherapist visited the facility weekly and asked if there were any issues with residents and staff reported behavior issues to her. Resident #3 was unavailable to be interviewed on 01/25/24 at 11:06am. Attempted telephone interview with the Operations Manager (OM) on 01/26/24 at 11:40pm was unsuccessful. Attempted telephone interview with Resident #3's psychotherapist on 01/26/24 at 1:22pm was unsuccessful. _____ The facility failed to notify the mental health provider for 1 of 5 sampled residents (#3) regarding the resident having aggressive behaviors which resulted in multiple verbal and physical altercations with other residents and inappropriate interactions with female residents. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided plan of protection in accordance with G.S. 131D-34 on 01/26/24 for this violation.	D 273		

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 _____	R-C 01/26/2024

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 273	Continued From page 40 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2024.	D 273		
{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: FOLLOW UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, record reviews and interviews, the facility failed to ensure residents were free of verbal and physical abuse from 1 resident (#3) for 2 of 8 sampled residents (#10 and #11) related to a resident who was pushed down and threatened (#10) and a resident who was hit (#11). The findings are: Review of the facility's undated policy on Resident's Rights revealed that every resident had the right to be free of mental and physical abuse, neglect, and exploitation. Review of Resident #3's current FL2 dated 03/09/23 revealed diagnoses included hypertension, schizophrenia, and vascular dementia.	{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 _____	R-C 01/26/2024

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 Review of Resident #3's care plan dated 06/12/23 revealed: -Resident #3 was usually calm, but he tended to get a little agitated when he ran out of cigarettes. -There was documentation Resident #3 was to be monitored daily for safety. -He socialized with other residents when he was outside. -He had a history of mental illness, was administered medications for mental illness/behavior, and was receiving mental health services. Review of Resident #3's psychotherapy progress notes dated 11/20/23 revealed: -Resident #3 was not currently a danger to himself or others -Treatment goals included decreasing inappropriate behavior by 50% as indicated by treatment team feedback, and patient feedback. -Resident #3 was to engage appropriately with staff and peers and was to have verbal physical, and sexual outbursts no more than quarterly. Review of Resident #3's psychotherapy progress note dated 12/04/23 revealed: -Resident #3 was not currently a danger to himself or others -Presenting symptoms included anger, delusions, and yelling. -Treatment goals included decreasing inappropriate behavior by 50% as indicated by treatment team feedback, and patient feedback. -Resident #3 was to engage appropriately with staff and peers and was to have verbal, physical, and sexual outbursts no more than quarterly. a. Review of Resident #10's current FL2 dated 10/03/23 revealed: -Diagnoses included Alzheimer's dementia with	{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 _____	R-C 01/26/2024

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}		

aggressive behaviors, congestive heart failure, diabetes mellitus, and persistent anxiety and depression.
-He was intermittently disoriented.
-He was semi-ambulatory with use of a cane or walker.

Review of Resident #10's Resident Register dated 09/27/23 revealed he was admitted to the facility on 09/27/23.

Review of Resident #10's care plan dated 10/02/23 revealed:
-He was social with staff and other residents in the common areas.
-He used a cane or a walker to assist with ambulation.
-He was forgetful and needed reminders.

Review of Resident #10's incident/accident report dated 12/10/23 revealed:
-At 12:05pm, Resident #10 had a witnessed altercation in the hallway.
-Resident #10 was standing in the hallway arguing with Resident #3, and the other resident pushed him across the floor.
-Resident #10 hit the floor on his back and side, laterality unspecified.
-There were no injuries present at the time of the incident.
-There was an additional note on the report documenting that on 12/11/23, Resident #10 woke up with his right wrist and hand swollen, so he was sent to urgent care for an evaluation.

Interview with a MA on 01/25/24 at 12:50pm revealed:
-She had completed the incident/accident report for the altercation between Resident #10 and Resident #3 on 12/10/23.

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 _____	R-C 01/26/2024

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 -On 12/10/23, Resident #3 was ranting and raving as usual. -Resident #3 was in the hallway calling an older female resident vulgar names and Resident #10 told Resident #3, "You don't have to talk to her like that." -Resident #3 turned around and shoved Resident #10 to the floor. -Resident #10 fell backwards and slid down the hallway on his back. -There were no complaints of pain or visible injuries to Resident #10 when she checked him over after separating him from the other resident. -There were no supervisors in the facility at the time of the altercation between Resident #10 and Resident #3, so she called the Operation's Manager (OM) to notify her about the incident. -She had not received any direction from the OM to increase supervision checks on either Resident #10 or Resident #3. -A different MA had sent Resident #10 to the urgent care on 12/11/23 where he was diagnosed with a right wrist fracture. Review of Resident #10's progress note dated 12/10/23 revealed: -A personal care aide (PCA)/medication aide (MA) documented that at approximately 12:09 pm that morning, Resident #10 was involved in a verbal altercation with Resident #3, which proceeded to turn physical. -Resident #3 pushed Resident #10 down in the hallway. -Staff separated the two residents and law enforcement was contacted. Review of Resident #10's urgent care visit note dated 12/11/23 revealed: -Resident #10 reported sustaining a fall the day prior and had pain and swelling in his right wrist.	{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 _____	R-C 01/26/2024

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 -An x-ray image of Resident #10's right wrist was ordered and revealed a deformity of the distal radius consistent with a nondisplaced fracture of indeterminate age. Review of Resident #10's orthopedic office visit note dated 12/13/23 revealed: -Resident #10 was being seen for a follow-up after sustaining a right wrist fracture. -Resident #10's wrist was placed in a cast and he should follow-up with orthopedic care in three weeks. Review of Resident #10's orthopedic office visit note dated 01/03/24 revealed: -Resident #10 was being seen for a follow-up after sustaining a right wrist fracture. -Examination of his right wrist revealed a well-fitting short arm cast. -Resident #10 had minimal swelling to his fingers and his motor function and sensation were intact. -An x-ray image taken that day revealed a fracture of the distal radius that was well aligned. -Resident #10 would continue cast immobilization of his right wrist and follow-up in three weeks to have the cast removed and complete repeat imaging. Review of Resident #10's orthopedic office visit note dated 01/24/24 revealed: -Resident #10 was being seen for a follow-up after sustaining a right wrist fracture. -He was doing well and in minimal pain. -Resident #10's right wrist revealed minimal swelling and was nontender; he had good range of motion to the wrist. -An x-ray image taken that day revealed a fracture of the distal radius that appeared to be almost completely healed. -Resident #10 would transition to using a brace	{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 _____	R-C 01/26/2024

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 on his right wrist for two weeks, then return to normal activities and follow up with orthopedic services as-needed. Observation of Resident #10 on 01/25/24 at 10:01am revealed Resident #10 was laying in bed in his room and had a black brace on his right arm. Interview with Resident #10 on 01/25/24 at 10:02am revealed: -Resident #3 liked to push and pick on women. -On 12/10/23, he tried to step between Resident #3 and a female resident when Resident #3 pushed him down to the floor. -When he fell, he put his arm down on the floor to try to break his fall and fractured his arm. -Staff took him to the hospital and the hospital placed a cast on his arm. -He just got the cast taken off his arm on 01/24/24, and the hard cast was replaced with a brace. -His right arm was in a lot of pain after he was pushed to the floor by Resident #3 and he was still in a little pain. -He was not afraid of Resident #3. Interview with a PCA/MA on 01/25/23 at 3:40pm revealed: -He had documented the progress note from 12/10/23 and had witnessed the altercation between Resident #10 and Resident #3. -On 12/10/23, he was in the dining hall when he heard Resident #3 and Resident #10 yelling at each other. -He did not hear what Resident #10 and Resident #3 had been arguing about but saw Resident #3 turn to face Resident #10, then Resident #10 falling backwards to the floor. -As Resident #10 was falling to the floor, he tried	{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 _____	R-C 01/26/2024

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	{D 338}		

to brace himself with his hands.
-After the altercation on 12/10/23, he tried to keep the two residents separated from each other.
-He had not been told by anyone to increase supervision checks on Resident #10 or Resident #3, but he did check on them both more frequently on 12/10/23.
-He did not document his increased supervision checks on 12/10/23.
-He had never been told to complete a 15-minute check form for Resident #10 or Resident #3.
-After the altercation on 12/10/23, Resident #10 was diagnosed with a right wrist fracture.
-Resident #10 had never reported to him that he felt unsafe in the facility or around Resident #3.

Interview with a resident on 01/26/24 at 10:20am revealed:
-Resident #3 was verbally aggressive towards women, and Resident #10 would stick up for the women.
-She had witnessed the altercation on 12/10/23 between Resident #10 and Resident #3.
-Resident #3 had been saying something to a female staff or resident, and Resident #10 stepped in and said something to him about it.
-Resident #3 became mad at Resident #10 and hit him.
-She felt intimidated by Resident #3 because he cussed a lot and was loud.

Interview with the Resident Care Coordinator (RCC) on 01/26/24 at 10:40am revealed:
-She was not at the facility on 12/10/23 when Resident #3 hit Resident #10.
-She had been told by staff that Resident #3 was at the medication room door upset that he was out of cigarettes, and Resident #10 got loud with Resident #3, and Resident #3 shoved Resident #10.

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 _____	R-C 01/26/2024

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 47 -When Resident #10 was landing on the floor, he tried to catch himself with his right hand and ended up fracturing it. -The staff told her that they had separated Resident #10 and Resident #3 and she advised the staff to keep them apart. -Resident #10 went to urgent care the following day, on 12/11/23, due to pain and swelling in his right wrist and hand and was diagnosed with a right wrist fracture and referred to an orthopedic specialist. -She had not advised staff to initiate increased supervision for Resident #10 or Resident #3 because once Resident #3 was redirected, he usually forgot the incident ever happened. Interview with the Administrator on 01/26/24 at 12:08pm revealed she was aware of the altercation between Resident #10 and Resident #3 on 12/10/23. Telephone interview with the Campus Director (CD) on 01/26/24 at 12:45pm revealed: -He had witnessed the altercation between Resident #10 and Resident #3 on 12/10/23. -Resident #10 provoked Resident #3 by telling him to be quiet while he was yelling, so Resident #3 pushed Resident #10. -He had asked Resident #10 to stop provoking Resident #3 because staff had the situation under control, but Resident #10 continued to talk to Resident #3 until Resident #3 pushed Resident #10. -Resident #10 went to urgent care and was diagnosed with a right wrist fracture. Attempted telephone interview with the OM on 01/26/24 at 11:40pm was unsuccessful. Attempted telephone interview with Resident	{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 _____	R-C 01/26/2024

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 48 #10's primary care provider (PCP) on 01/25/23 at 3:25pm was unsuccessful. Refer to interview with the RCC on 01/26/24 at 10:40am. Refer to interview with the Administrator on 01/26/24 at 12:08pm. Refer to telephone interview with the CD on 01/26/24 at 12:45pm. b. Interview with a resident on 01/25/24 at 9:40am revealed he observed Resident #3 trying to stab Resident #10 with a fork about a week ago. Review of Resident #10's incident/accident reports revealed there was no report dated 01/21/24. Review of Resident #10's progress notes revealed there was no documentation from 01/21/24. Interview with Resident #10 on 01/25/24 at 10:02am revealed: -Resident #3 liked to push other residents around. -Resident #3 had pushed him in December 2023. -Someone told him Resident #3 tried to stab him with a fork in the dining hall, but he did not remember the incident. Interview with the Operations Manager (OM) on 01/25/24 at 11:08am revealed she was not aware of any incident or altercation happening between Resident #10 and Resident #3 on 01/21/24. Interview with a PCA/MA on 01/25/24 3:40pm revealed:	{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 _____	R-C 01/26/2024

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 49 -On 01/21/24, he was in the dining room passing meal trays when Resident #10 asked Resident #3 to cover his mouth while he was coughing. -Resident #3 became angry at Resident #10 and started yelling and cussing at him. -Resident #3 drew back his hand wielding a fork and looked like he was threatening to stab Resident #10 with it. -He immediately stepped between the two residents and took the fork from the other resident's hand. -He asked Resident #3 to sit down at his seat and there were no further altercations between Resident #10 and Resident #3. -He had not been told by anyone to increase supervision checks or to do anything differently for Resident #10 or Resident #3 after the incident subsided. -Resident #10 was not injured from the altercation. -Resident #10 had never reported to him that he felt unsafe in the facility or around Resident #3. Interview with another PCA on 01/25/24 at 4:10pm revealed: -She was working the day Resident #3 wielded a fork at Resident #10 in the dining room. -She heard yelling in the dining room so she went into the dining room to see the MA/PCA standing between the two residents. -Resident #10 had been sitting at his table, and Resident #3 was standing and had his fist raised. -The MA/PCA took a fork from Resident #3's hand, then Resident #3 stormed out of the dining room cussing. -After the incident ended, staff were not advised to do anything differently regarding monitoring Resident #10 or Resident #3 for safety. -The altercation was reported to whoever the MA was but she could not remember which MA was	{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 _____	R-C 01/26/2024

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 50	{D 338}		

working that day.
-She had not documented anything about the incident because PCAS were not allowed to document progress or chart notes.

Interview with another resident on 01/26/24 at 10:20am revealed:
-She had witnessed the altercation between Resident #10 and Resident #3 in the dining room on 01/21/24.
-Resident #3 yelled at Resident #10, and lifted up his fork like he was going to stab Resident #10 with it.
-One of the PCAs told Resident #3 to calm down and leave the dining room, so he did.
-Resident #3 was loud and intimidating.

Interview with a third resident on 01/26/24 at 10:35am revealed:
-Resident #3 had an anger issue and had called him vulgar names before without being provoked.
-There was an incident in the dining room a few days ago involving Resident #3 and Resident #10.
-Resident #3 was coughing without covering his mouth and Resident #10 told him to cover his mouth.
-Resident #3 got mad when Resident #10 told him to cover his mouth, and he (Resident #3) got up and charged aggressively at Resident #10.
-He did not know if Resident #3 was holding a fork when he charged at Resident #10.
-Resident #3 regularly had angry outbursts and yelled at staff and residents.

Interview with the Resident Care Coordinator (RCC) on 01/26/24 at 10:40am revealed:
-She was not aware that Resident #3 raised a fork to threaten Resident #10 on 01/21/24.
-Resident #3 was very easily triggered by things

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 _____	R-C 01/26/2024

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 51 other residents said to him. -Due to his diagnoses, Resident #3 would have an aggressive outburst when he was upset, then forget about the entire situation shortly thereafter. Interview with the Administrator on 01/26/24 at 12:08pm revealed she was not aware of the incident on 01/21/24 between Resident #10 and Resident #3 in the dining room. Telephone interview with the Campus Director (CD) on 01/26/24 at 12:45pm revealed he was not aware of the incident on 01/21/24 between Resident #10 and Resident #3 in the dining room. Attempted telephone interview with the OM on 01/26/24 at 11:40pm was unsuccessful. Attempted telephone interview with Resident #10's primary care provider (PCP) on 01/25/23 at 3:25pm was unsuccessful. Refer to interview with the RCC on 01/26/24 at 10:40am. Refer to interview with the Administrator on 01/26/24 at 12:08pm. Refer to telephone interview with the CD on 01/26/24 at 12:45pm. c. Review of Resident #11's current FL2 dated 03/23/23 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, diabetes, and chronic obstructive pulmonary disease. -He was intermittently disoriented. -He was ambulatory. Review of Resident #11's care plan dated	{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 _____	R-C 01/26/2024

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 52 01/25/23 revealed: -He enjoyed being around the other residents. -He was forgetful and needed reminders. Interview with two residents during the tour of the facility revealed they saw Resident #3 hit Resident #11 in the face on the outside patio smoking area. Interview with Resident #11 on 01/25/24 at 9:40am revealed: -A few weeks ago, he was sitting at a picnic table in the outside patio smoking area and Resident #3 was standing in a corner. -Resident #3 just came up to him and hit him on the right side of his face in the temple area and walked away; his head still hurt. -Resident #3 also punched him in his right jaw in the cafeteria, but he did not remember when. -He had seen Resident #3 hit a couple other residents, but he did not remember the residents' names. -He felt like he could not let his guard down when Resident #3 was around because Resident #3 might hit or hurt him. -He was afraid of Resident #3, but he had not told staff that he was afraid. Interview with the OM on 01/25/24 at 11:08am revealed: -Resident #11 did not have any incident/accident reports. -She was not aware of Resident #11 having any altercations or incidents with any of the other residents in the previous 6 months. Interview with a PCA on 01/25/24 at 11:29am revealed: -It did not take much to trigger Resident #3 before he became physically or verbally aggressive.	{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 _____	R-C 01/26/2024

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 53 -She observed Resident #3 hit at least 3 residents since she worked at the facility. -She thought management was aware of Resident #3's behaviors because staff were told to keep an eye on him. -She was working the day Resident #3 hit Resident #11 on the outside patio smoking area, a few weeks ago. -Another resident came to her and told her Resident #3 was hitting and kicking Resident #11. -When she arrived to the outside patio, Resident #3 was standing over Resident #11 with his fists balled up. -Resident #3's behaviors were worse when he did not have cigarettes. Interview with a MA on 01/25/24 at 12:50am revealed: -Other residents had witnessed Resident #3 hit Resident #11 on the smoking patio. -She was not sure when the altercation had occurred but thought it was a couple of months prior. -A resident had come into the facility from the smoking patio and reported to staff that Resident #11 had been hit by Resident #3, so she went outside and saw the other resident cussing at Resident #11. -Resident #11 was sitting on a picnic table and when she asked him what had happened, he told her that he did not know what was wrong with Resident #3 for hitting him. -Resident #11 said he was not injured. -She had been working in the role of PCA that day and had reported the altercation to the MA on duty, but she could not remember which MA it was. -She had not documented anything about the altercation between Resident #11 and Resident #3 because it had not been witnessed and she	{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 _____	R-C 01/26/2024

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 54	{D 338}		

did not know what exactly had happened.
-She was not told to increase monitoring of Resident #11 or Resident #3 after the reported physical altercation between them.
-After any altercation between residents, staff were expected to watch both residents closely so that no further altercation could take place, but they did not document it.

Interview with another PCA on 01/25/24 at 4:10pm revealed:
-She was working the day Resident #11 was hit by Resident #3.
-A resident came inside from the smoking porch and told her that Resident #3 hit Resident #11.
-She went out to the smoking porch and saw Resident #11 standing over Resident #3, who was sitting on the seat of a picnic table, with his fist raised.
-Resident #11 was not trying to fight Resident #3 back.
-Resident #11 denied being hurt.
-Resident #11 told her that Resident #3 walked up to him cursing at him then hit and kicked him.
-She had reported the incident to the MA, but could not remember which one.

Interview with Resident #11's primary care provider (PCP) on 01/25/24 at 12:10pm revealed:
-She was not aware of any physical altercations between Resident #11 and Resident #3.
-If Resident #11 had been physically assaulted by another resident, she would want to be updated.

Interview with the Resident Care Coordinator (RCC) on 01/26/24 at 10:40am revealed:
-She was not aware that Resident #11 was hit on the smoking patio by Resident #3.
-She asked the MAs in the past to complete an incident report for any physical altercation

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 _____	R-C 01/26/2024

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 55 between residents. -The staff usually trusted the residents when they reported an altercation, but it was possible the MAs and PCAs had not documented the altercation between Resident #11 and Resident #3 because they had not witnessed it happening. -The MA who was working on the day of the altercation was responsible for reporting it to her, and she would be responsible for reporting the altercation to the OM. Interview with the Administrator on 01/26/24 at 12:08am revealed: -She was not aware of the physical altercation between Resident #11 and Resident #3 on the smoking patio. -She would have wanted the MA to complete an incident/accident report and for the PCA to document what she was told by the other resident, and what she had seen when she went on the smoking patio. -When staff witnessed two residents having either a verbal or physical altercation, they were expected to intervene and de-escalate the situation. -She did not know what the staff did each shift to keep the residents safe other than keeping an eye on them. Telephone interview with the Campus Director (CD) on 01/26/24 at 12:45pm revealed he was not aware of the physical altercation between Resident #11 and Resident #3. Refer to interview with the RCC on 01/26/24 at 10:40am. Refer to interview with the Administrator on 01/26/24 at 12:08pm.	{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 _____	R-C 01/26/2024

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 56 Refer to telephone interview with the CD on 01/26/24 at 12:45pm. _____ Interview with the RCC on 01/26/24 at 10:40am revealed: -There was no plan in place to protect residents from other residents. -The staff just always kept an eye on the residents throughout their shift. -She never heard a resident complain about not feeling safe at the facility, but she had heard residents say things like they wished they did not have to deal with the loud residents and the fighting. -The facility completed a training inservice on Resident's Rights in December 2023. -The Resident's Rights training taught staff about what the residents' needs were and what staff were supposed to do to meet those needs and how they should treat the residents. -If staff witnessed a violation of a right, they were supposed to report it to either the OM or the CD right away. Interview with the Administrator on 01/26/24 at 12:08pm revealed: -When physical altercations occurred between two residents, she expected the staff to intervene and attempt to de-escalate the situation between the two residents. -Whichever staff was in charge at the time of the incident was responsible for reporting it to the RCC. -She expected the MAs and PCAs to increase supervision checks for residents who were involved in an altercation, and if a resident was aggressive, they should be placed on 15-minute checks and the checks should be documented on. -She was not aware of Resident #3 being on	{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 _____	R-C 01/26/2024

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 57 15-minute checks. -She had expressed her expectations regarding increased supervision checks to staff. -She had arranged for the ombudsman to do an inservice at the facility with all of the staff in December 2023. -Staff were trained that if they saw a resident's right being violated, they were to immediately report it to the CD. -She was not aware of any reports being made to the CD regarding residents' rights. -She was unsure if the facility's staff were aware that physical assault between residents was a resident's rights issue. Telephone interview with the CD on 01/26/24 at 12:45pm revealed: -The ombudsman had been at the facility in December 2023 to do an inservice with staff about each resident right and explaining how staff were responsible to respond to and protect each right. -There had not been an inservice or education meeting with staff regarding the altercation between Resident #10 and the other resident. _____ The facility failed to protect residents from physical, mental and verbal abuse by not having systems of interventions in place for the residents related to a resident who was pushed down following a verbal altercation with Resident #3 resulting in a fractured wrist, and was threatened to be stabbed with a fork in the dining room (#10), and a resident who was hit in the head and kicked by Resident #3 (#11). This failure placed residents at substantial risk of physical harm, and neglect which constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in	{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 _____	R-C 01/26/2024

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 58 accordance with G.S. 131D-34 on 01/25/24 for this violation. CORRECTION DATE FOR THE UNABATED TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	{D 338}		