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CEDARBROOK RESIDENTIAL CENTER	**1267 PINNACLE CHURCH ROAD NEBO, NC 28761**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and a complaint investigation on 01/04/24, 01/05/24 and 01/08/24 through 01/12/24, with a desk review from 01/16/24 through 01/19/24 and 01/22/24 through 01/26/24 with a telephone exit on 01/26/24.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to ensure at least one staff person was on the premises for each shift, who successfully completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 12 of 13 sampled days from 12/19/23 through 12/31/23.	D 167		

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D 167	Continued From page 1 The findings are: Review of the facility's personnel files revealed: -There were twenty staff who provided direct resident care. -Fourteen of the twenty staff had no current documentation of completing a course in CPR within the last 24 months. Review of the listing of employees with current CPR and the time punch detail report dated 12/19/23 revealed there were no CPR certified staff in the building for 7 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/20/23 revealed there were no CPR certified staff in the building for 10.75 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/21/23 revealed there were no CPR certified staff in the building for 10 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/22/23 revealed there were no CPR certified staff in the building for 9 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/23/23 revealed there were no CPR certified staff in the building for 19 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/24/23 revealed there were no CPR certified staff in the building for 7 hours. Review of the listing of employees with current	D 167		

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D 167	Continued From page 2 CPR and the time punch detail report dated 12/25/23 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/26/23 revealed there were no CPR certified staff in the building for 9 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/27/23 revealed there were no CPR certified staff in the building for 9 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/28/23 revealed there were no CPR certified staff in the building for 8.50 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/30/23 revealed there were no CPR certified staff in the building for 7 hours. Review of the listing of employees with current CPR and the time punch detail report dated 12/31/23 revealed there were no CPR certified staff in the building for 11 hours. Telephone interview with a personal care aide (PCA) on 01/11/24 at 3:14 pm revealed: -She and another PCA, and a medication aide (MA) were working on 12/23/24 when a resident had a seizure. -She was not sure if the resident's seizure warranted CPR. -She was not CPR certified. -The MA she was working with told her she was not CPR certified. -The other PCA that was working with her and all	D 167		

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other staff working in the kitchen were not CPR certified.

Interview with the Operations Manager on 01/11/24 at 4:41pm revealed:
-She was not aware there were periods of time between 12/19/23 and 12/31/23 when there were no CPR certified staff working in the building.
-Some staff's CPR training had expired but she hoped they would perform CPR in an emergency.
-If staff were involved in an emergency that required CPR for a resident, and did not have CPR training, staff knew to call 911 and follow the instructions from the dispatcher.

____

The facility failed to ensure at least one CPR certified staff was always on the premises for 12 of 13 sampled days, including 12/23/23 when a resident had a medical emergency and the staff providing care during the emergency realized there was no staff on the premises who was CPR certified. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/11/24 for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 11, 2024.

D 188 — 10A NCAC 13F .0604(e)(1) Personal Care And Other Staffing — D 188

10A NCAC 13F .0604 Personal Care And Other Staffing
(e) Homes with capacity or census of 21 or more

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D 188	Continued From page 4 shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.	D 188		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, record reviews, and interviews the facility failed to ensure the required aide duty hours were met for 5 of 13 first shifts, 8 of 13 second shifts, and 11 of 13 third shifts sampled from 12/19/23 to 12/31/23.

The findings are:

Review of the facility's current license issued by the Division of Health Service Regulation effective January 1, 2024, revealed the facility was licensed for a capacity of 80 beds for an Adult Care Home.

Observation during the initial tour on 01/04/24 at 9:00am revealed the facility was not sprinkled for fire suppression.

Review of the facility's census for 12/19/23 to 12/31/23 revealed there were 62 to 68 residents which required 28 aide duty hours on first shift and second shift and 24 aide duty hours on third shift.

Review of the facility's residents receiving Personal Care Services (PCS) revealed:
-A total of 47 residents received PCS.
-There were 5 of 7 sampled residents who received PCS.
-There were 4 of 5 sampled residents who required limited assistance three times weekly with bathing and 1 who required extensive assistance.

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-All 5 residents required extensive assistance, 7 days a week, with dressing and extensive assistance weekly with shaving.

Observation on 01/09/24 at 6:08am revealed there was one personal care aide (PCA) and one medication (MA) working in the facility and available to provide resident care.

1. Review of the facility's census for 12/19/23 to 12/31/23 revealed there were 62 to 68 residents which required 28 aide duty hours on first shift.

Review of the employee time punch detail report and the OM's work calendar dated 12/23/23 revealed there was a total of 21.75 aide duty hours provided on first shift with a shortage of 6.25 aide duty hours.

Review of the employee time punch detail report and the Operations Manager's (OM's) work calendar dated 12/25/23 revealed there was a total of 27.25 aide duty hours provided on first shift with a shortage of 0.75 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/26/23 revealed there was a total of 25.50 aide duty hours provided on first shift with a shortage of 2.50 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/30/23 revealed there was a total of 19.75 aide duty hours provided on first shift with a shortage of 8.25 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/31/23 revealed there was a total of 26.25 aide duty

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hours provided on first shift with a shortage of 1.75 aide duty hours.

Refer to telephone interview with a third shift PCA on 01/12/24 at 2:35pm.

Refer to interviews with the OM on 01/11/24 at 9:22am, 01/12/24 at 4:02pm, and on 01/19/24 at 11:30am and 3:08pm.

Refer to interview with a medication aide (MA) on 01/09/24 at 6:26am.

Refer to interview with the Administrator on 01/11/24 at 3:49pm.

2. Review of the facility's census for 12/19/23 to 12/31/23 revealed there were 62 to 68 residents which required 28 aide duty hours on second shift.

Review of the employee time punch detail report and the OM's work calendar dated 12/20/23 revealed there was a total of 27.25 aide duty hours provided on second shift with a shortage of 0.75 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/22/23 revealed there was a total of 25 aide duty hours provided on the second shift with a shortage of 3 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/23/23 revealed there was a total of 24 aide duty hours provided on second shift with a shortage of 4 aide duty hours.

Review of the employee time punch detail report

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and the OM's work calendar dated 12/24/23 revealed there was a total of 25.25 aide duty hours provided on the second shift with a shortage of 2.75 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/25/23 revealed there was a total of 27.75 aide duty hours provided on second shift with a shortage of 0.25 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/27/23 revealed there was a total of 26.25 aide duty hours provided on second shift with a shortage of 1.75 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/29/23 revealed there was a total of 21 aide duty hours provided on second shift with a shortage of 7 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/30/23 revealed there was a total of 22.00 aide duty hours provided on second shift with a shortage of 6 aide duty hours.

Refer to telephone interview with a third shift PCA on 01/12/24 at 2:35pm.

Refer to interviews with the OM on 01/11/24 at 9:22am, 01/12/24 at 4:02pm, and on 01/19/24 at 11:30am and 3:08pm.

Refer to interview with a medication aide (MA) on 01/09/24 at 6:26am.

Refer to interview with the Administrator on

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D 188	Continued From page 9 1/11/24 at 3:49pm. 3. Review of the facility's census for 12/19/23 to 12/31/23 revealed there were 62 to 68 residents which required 24 aide duty hours on third shift. Review of the employee time punch detail report and the OM's work calendar dated 12/19/23 revealed there was a total of 15.25 aide duty hours provided on third shift with a shortage of 8.75 aide duty hours. Review of the employee time punch detail report and the OM's work calendar dated 12/20/23 revealed there was a total of 22.25 aide duty hours provided on third shift with a shortage of 1.75 aide duty hours. Review of the employee time punch detail report and the OM's work calendar dated 12/21/23 revealed there was a total of 23 aide duty hours provided on third shift with a shortage of 1 aide duty hours. Review of the employee time punch detail report and the OM's work calendar dated 12/22/23 revealed there was a total of 23.50 aide duty hours provided on third shift with a shortage of 0.50 aide duty hours. Review of the employee time punch detail report and the OM's work calendar dated 12/23/23 revealed there was a total of 21 aide duty hours provided on third shift with a shortage of 3 aide duty hours. Review of the employee time punch detail report and the OM's work calendar dated 12/25/23 revealed there was a total of 16 aide duty hours provided on third shift with a shortage of 8 aide	D 188		

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duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/26/23 revealed there was a total of 17.50 staff hours provided on third shift with a shortage of 6.50 hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/27/23 revealed there was a total of 8.25 aide duty hours provided on third shift with a shortage of 15.75 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/28/23 revealed there was a total of 11.5 aide duty hours provided on third shift with a shortage of 12.50 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/30/23 revealed there was a total of 16 aide duty hours provided on third shift with a shortage of 8 aide duty hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/31/23 revealed there was a total of 19.25 aide duty hours provided on third shift with a shortage of 4.75 aide duty hours.

Refer to telephone interview with a third shift PCA on 01/12/24 at 2:35pm.

Refer to interviews with the OM on 01/11/24 at 9:22am, 01/12/24 at 4:02pm, and on 01/19/24 at 11:30am and 3:08pm.

Refer to interview with a medication aide (MA) on

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01/09/24 at 6:26am.

Refer to interview with the Administrator on 01/11/24 at 3:49pm.

____

Telephone interview with a third shift PCA on 01/12/24 at 2:35pm revealed:
-She had worked some nights when it was only her and one MA.
-She sat outside the medication room in the hallway at night so she could observe what was going on in the facility.

Interview with the OM on 01/11/24 at 9:22am and 01/12/24 at 4:02pm revealed:
-She was responsible for completing the staffing schedule.
-She provided all of the aides' recorded time along with her time worked and she did not have any additional information.
-For third shift she usually had 3 staff working in the building, depending on the census.
-If there were only 2 staff present for third shift she would come to the facility and work.
-She was unaware only 2 staff worked on third shift five of the thirteen reviewed days in December 2023.
-She was a salaried employee and did not clock in and out for the shifts she covered.
-She worked a lot during December 2023 due to staff illnesses and call outs.
-The facility struggled with employees leaving.
-She did not have staff present just to cover hours.

Interview with the OM on 01/19/24 at 11:30am and 3:08pm revealed:
-There were approximately 40 residents who received PCS.
-Most of the residents who received services

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needed limited assistance with things like bathing, dressing, and grooming.
-Not many residents needed extensive assistance.
-She knew there was a shortage of aide duty hours on third shift but did not know there was a shortage on first or second shift.
-If there was a shortage on first shift, it had to be on a weekend.
-There would have never been a time that only PCAs were in the building without a MA that she was aware of.
-There had never been a time that a MA was not in the building on third shift; the PCAs would have been "freaking out".

Interview with a medication aide (MA) on 01/09/24 at 6:26am revealed:
-There was an incident on 12/23/23 where she and a personal care aide (PCA) were smoking, and a resident was being verbally aggressive, cursing and yelling and started swinging a sock that contained a large rock.
-If there was an incident with a resident she usually completed an incident report, a shift report and then verbally reported the incident to the OM and the RCC.
-She reported the incident on 12/23/23 to the 2nd shift MA at the end of her shift but she did not complete an incident report because she was busy and "I had to keep the 67 residents safe" and "I'm only one person".

Interview with the Administrator on 1/11/24 at 3:49pm revealed:
-Third shift staffing required a supervisor and 2 PCAs when the census was in the 60's.
-She thought there was enough staff coverage if there were 2 staff in the building and there was a supervisor within 500 feet.

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D 188	Continued From page 13 Attempted interview with a third shift MA on 01/12/24 at 10:00am was unsuccessful. ______________________ The facility failed to have required aide duty hours in the facility to provide supervision and care for 62 to 68 residents on 1st shift for 5 of 13 days, 2nd shift for 8 of 13 days, and 3rd shift for 11 of 13 days from 12/19/23 through 12/31/23 which could result in the residents not receiving appropriate supervision, assistance with their care needs and hinder the residents' ability to evacuate the facility in case of an emergency. This failure was detrimental to the health and safety of all the residents and constitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/19/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2024.	D 188		
D 212	10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (a) On first and second shifts in facilities with a capacity or census of 31 or more residents and on third shift in facilities with a capacity or census of 91 or more residents, there shall be at least one supervisor of personal care aides, hereafter referred to as supervisor, on duty in the facility for less than 64 hours of aide duty per shift; two supervisors for 64 to less than 96 hours of aide duty per shift; and three supervisors for 96 to less	D 212		

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than 128 hours of aide duty per shift. In facilities sprinklered for fire suppression with a capacity or census of 91 to 120 residents, the supervisor's time on third shift may be counted as required aide duty. (For staffing chart, see Rule .0606 of this Section.)

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to meet the required staffing hours to ensure a personal care aide (PCA) Supervisor was on duty in the facility and available on first shift for 11 of 13 days, second shirt for 9 of 13 days and on third shift for 10 of 13 days from 12/19/23 to 12/31/23.

The findings are:

Review of the facility's current license issued by the Division of Health Service Regulation effective January 1, 2024, revealed the facility was licensed for a capacity of 80 beds for an Adult Care Home and had a census of 63.

Observation during the initial tour on 01/04/24 at 9:00am revealed the facility was not sprinkled for fire suppression.

Review of the facility census records from 12/19/23 to 12/31/23 revealed there was a census of 62 to 68 residents which required 8 Supervisor hours on duty in the facility on first and second shifts and 4 Supervisor hours on duty in the facility on third shift.

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Review of the employee time punch detail report and the Operation Manager's (OM's) work calendar dated 12/19/23 revealed there was a total of 0.25 Supervisor hours provided on third shift with a shortage of 3.75 Supervisor hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/20/23 revealed:
-There was a total of 6.5 Supervisor hours provided on the first shift with a shortage of 1.5 Supervisor hours.
-There was a total of 4.25 Supervisor hours provided on the second shift with a shortage of 3.75 Supervisor hours.
-There was a total of 0.25 Supervisor hours provided on the third shift with a shortage of 3.75 Supervisor hours.

Review of the employee time punch detail report and the OM's work calendar dated 12/21/23 revealed:
-There was a total of 6.5 Supervisor hours provided on the first shift with a shortage of 1.5 Supervisor hours.
-There was a total of 7 Supervisor hours provided on the second shift with a shortage of 1 Supervisor hour.
-There were no Supervisor hours provided on the third shift.

Review of the employee time punch detail report and the OM's work calendar dated 12/22/23 revealed:
-There was a total of 7 Supervisor hours provided on the first shift with a shortage of 1 Supervisor hour.
-There was a total of 7.25 Supervisor hours provided on the second shift with a shortage of 0.75 Supervisor hours.

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D 212	Continued From page 16 -There were no Supervisor hours provided on the third shift. Review of the employee time punch detail report and the OM's work calendar dated 12/23/23 revealed: -There were no Supervisor hours provided on the first shift. -There was a total of 4 Supervisor hours provided on the second shift with a shortage of 4 Supervisor hours. -There was a total of 1 Supervisor hour provided on the third shift with a shortage of 3 Supervisor hours. Review of the employee time punch detail report and the OM's work calendar dated 12/24/23 revealed: -There was a total of 6.75 Supervisor hours provided on the first shift with a shortage of 1.25 Supervisor hours. -There was a total of 2.25 Supervisor hours provided on the second shift with a shortage of 5.75 Supervisor hours. Review of the employee time punch detail report and the OM's work calendar dated 12/25/23 revealed there were no Supervisor hours provided on first, second or third shifts. Review of the employee time punch detail report and the OM's work calendar dated 12/26/23 revealed: -There was a total of 7 Supervisor hours provided on the first shift with a shortage of 1 Supervisor hour. -There was a total of 7.75 Supervisor hours provided on the second shift with a shortage of 0.25 Supervisor hours. -There were no Supervisor hours provided on the	D 212		

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D 212	Continued From page 17 third shift. Review of the employee time punch detail report and the OM's work calendar dated 12/27/23 revealed: -There was a total of 5.5 Supervisor hours provided on the first shift with a shortage of 2.5 Supervisor hours. -There was a total of 1 Supervisor hour provided on the third shift with a shortage of 3 Supervisor hours. Review of the employee time punch detail report and the OM's work calendar dated 12/28/23 revealed: -There was a total of 6.5 Supervisor hours provided on the first shift with a shortage of 1.5 Supervisor hours. -There was a total of 7.75 Supervisor hours provided on the second shift with a shortage of 0.25 Supervisor hours. Review of the employee time punch detail report and the OM's work calendar dated 12/30/23 revealed: -There was a total of 6 Supervisor hours provided on the first shift with a shortage of 2 Supervisor hours. -There was a total of 3.25 Supervisor hours provided on the third shift with a shortage of 0.75 Supervisor hours. Review of the employee time punch detail report and the OM's work calendar dated 12/31/23 revealed: -There was a total of 6 Supervisor hours provided on the first shift with a shortage of 2 Supervisor hours. -There was a total of 6.5 Supervisor hours provided on the second shift with a shortage of	D 212		

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D 212	Continued From page 18 1.5 Supervisor hours. -There was a total of 1 Supervisor hour provided on the third shift with a shortage of 3 Supervisor hours. Interview with the OM on 01/11/24 at 9:22am, on 01/12/24 at 4:02pm and on 01/19/24 at 11:30am and at 3:00pm revealed: -She was responsible for completing the staffing schedule. -There was a total of four Supervisors working at the facility. -Not all medication aides (MAs) were Supervisors or had 12 hours of continuing education related to the care of aged or disabled persons. -She would work as the Supervisor if there was no Supervisor coverage. -She knew there were issues on the third shift with Supervisor and staff coverage. -She did not realize she had to be in the building for 4 of the 8 hours on third shift when she was the Supervisor within 500 feet of the facility. Interview with the Administrator on 01/11/24 at 3:49pm revealed she thought there would be enough staff coverage on third shift if two staff were in the building on and there was a Supervisor within 500 feet of the facility. ________________________ The facility failed to ensure a personal care aide Supervisor was on duty in the facility and available on 1st shift for 11 of 13 days, 2nd shift for 9 of 13 days, and 3rd shift for 10 of 13 days from 12/19/23 through 12/31/23 to ensure staff were providing care and services in a safe and secure manner. This failure was detrimental to the health and safety of all the residents and constitutes a Type B Violation. ________________________ The facility provided a plan of protection in	D 212		

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accordance with G.S. 131D-34 on 01/19/24 for this violation.

THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2024.

D 456 10A NCAC 13F .1212(g) Reporting of Accidents and Incidents D 456

10A NCAC 13F .1212 Reporting of Accidents and Incidents
(g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately:
(1) seek the assistance of the local law enforcement authority;
(2) provide additional supervision of the threatening resident to protect others from harm;
(3) seek any needed emergency medical treatment;
(4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
(5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

This Rule is not met as evidenced by:
A1 VIOLATION

Based on interviews and record reviews, the facility failed to seek the assistance of local law enforcement (LLE) for 4 residents related to a physical assault with injury (Resident #2 & #4), a

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physical assault without injury (Resident #1 & #3), and an incidence that put a resident at risk of physical harm (Resident #3).

The findings are:

Review of the facility policy on Management of Physical Aggression or Assault revealed:
-Staff will be alert to inappropriate behaviors.
-Staff will report any maladaptive behaviors immediately to the supervisor.
-Staff will deescalate situations as needed.
-Staff will report dangerous behaviors to the resident's physician and or mental health authority and implement any physician orders.
-Staff will report dangerous behaviors to the resident's family or responsible person and seek intervention.
-Staff will call appropriate law enforcement if all interventions fail.

1. Review of physical assault with injury between Resident #2 and Resident #4.

a. Review of Resident #2's current FL2 dated 12/09/23 revealed diagnoses included pneumonia, diabetes, and acute schizoaffective disorder.

Review of an incident report for Resident #2 dated 12/13/23 revealed:
-The report was completed by the facility's Administrative Assistant.
-Resident #2 was involved in an altercation with another male resident; both residents were hitting one another when he was hit in the face and legs.
-There was documentation ice was applied and the residents were redirected without further problem.
-There was no documentation local law

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enforcement (LLE) was called on 12/13/23.

Interview with a paramedic with local emergency medical services on 01/08/24 at 1:00pm revealed:
-He responded to a call for assistance at the facility on 12/23/23 because Resident #2 was reported to be having a seizure.
-An employee at the facility reported to him that Resident #2 had been in an altercation with another resident serveral days prior.
-He assessed Resident #2 prior to him being transported to the hospital on 12/23/23.
-Resident #2 had an area on his face under the left side of his face below that appeared to him to be a healing area that he observed to be purple turning yellow in color.

Interview with Resident #2's Primary Care Provider (PCP) on 01/09/23 at 1:06pm revealed:
-He last saw the resident on 12/21/23.
-He observed that the resident had a bruised cheek caused by another resident who punched him in the face during a physical altercation on 12/13/23.

Review of the 911 call report from the local county sheriff's office revealed 911 was not called at the time of the incident on 12/13/23.

b. Review of Resident #4's current FL2 dated 08/25/23 revealed diagnoses included mechanical complication of internal left knee and generalized muscle weakness.

Interview with Resident #4 on 01/04/24 at 11:00am revealed:
-He was in the hallway in his wheelchair on 12/13/23 with his left leg extended due to a recent surgery.
-Resident #2 was in the hallway, in his wheelchair

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at the same time propelling himself toward Resident #4.
- Resident #2 did not stop propelling himself directly at him and crashed his wheelchair into Resident #4's wheelchair.
-Resident #4 hit Resident #2 in the face with his fist.

Review of the Resident Life Enrichment Coordinator's progress notes dated 12/13/23 revealed:
-Staff reported Resident #2 was in his wheelchair and ran in to Resident #4 who was in his wheelchair and the two wheelchairs got stuck together.
-Resident #4 then punched Resident #2 because Resident #2 would not stop talking loudly when Resident #4 asked him to.

Review of an incident report for Resident #2 dated 12/13/23 revealed:
-At 12:20pm in the hallway, Resident #4 and Resident #2 were involved in an altercation.
-Resident #4 reported Resident #2 was coming toward him in his wheelchair and would not stop running into him.
-Both residents were "swinging fists."
-Resident #4 was not injured.
-Resident #4 was alert and oriented and had no injury from the altercation with Resident #2.
-There was no documentation local law enforcement (LLE) was called.

Review of Resident #4's most recent Mental Health Provider (MHP) notes dated 02/03/23 revealed:
-Resident #4 had been displaying anger and aggression towards others in the facility over a two-week period.
-On 02/03/23 Resident #4's behavior escalated,

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and he threatened to assault another resident with a plastic knife.
-Resident #4 refused to comply with completing a mental health crisis assessment.
-Resident #4 slammed the door in a staff member's face and said, "[racial slurs]."
-Resident #4 was involuntarily comitted to the hospital for psychiatric evaluation and treatment.

Interview with the Administrative Assistant on 01/08/24 at 3:24pm revealed:
-She completed the Incident Report for the altercation that occurred between Resident #4 and Resident #2 on 12/13/23.
-The incident was witnessed by and reported to her by a medication aide (MA) who no longer worked at the facility.
-Residents #4 and #2 were intertwined in their wheelchairs in the hallway and they were "swinging fists."
-She spoke to Resident #4 who stated Resident #2 "just kept coming at me and coming at me."
-Resident #4 was not injured to her knowledge.

Interview with the Resident Care Coordinator (RCC) on 01/05/24 at 10:32am revealed:
-Resident #4 hit Resident #2 in the eye because Resident #2 was cursing and told Resident #4 that he was going to run into him with his wheelchair.
-She was not present during the incident.

Interview with the Operations Manager (OM) on 01/05/24 at 11:42am and 2:53pm revealed:
- Resident #2 ran into Resident #4 in his wheelchair.
-There were fists thrown.
-Resident #4 was uninjured, but Resident #2's eye was blackened.
-She was not sure if the involved residents were

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placed on 15-minute checks after the incident.
-When there was a physical altercation between residents; staff were trained to redirect the residents or call mobile crisis if they could not be redirected or calmed down.
-She was not aware LLE needed to be contacted if the guardians and the residents involved in an assault did not want to press charges.
-LLE would be contacted if the resident requested LLE become involved.
-She did not think LLE was contacted after the 12/13/23 assault.

Review of the 911 call report revealed 911 was not called at the time of the incident on 12/13/23.

Refer to Telephone interview with a Detective from LLE on 01/12/224 at 2:51pm.

Refer to interview with the Administrator on 01/11/24 at 4:16pm.

2. Review of a physical altercation between Resident #3 and Resident #1.

a. Review of Resident #3's current FL2 dated 02/07/23 revealed:
-Diagnoses included dementia with behavior disturbances and history of traumatic brain injury.
-Resident #3 used a wheelchair for ambulation.

Interview with Resident #3 on 01/04/24 at 10:24am and 01/09/24 at 10:06am revealed:
-He was partially paralyzed and propelled himself in a wheelchair.
-About a week ago, Resident #1 threatened to turn him over in his wheelchair, when they were in the hall, outside the dining room.
-He started to swing a sock around that had a rock in it.

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-It took 4 people to take the sock away from him.
-He made the sock with the rock in it about a year ago for protection because he did not trust anyone.
-No one at the facility ever knew he had the sock with a rock in it; he kept it on the seat of his wheelchair behind him where it could not be seen.
-The first time he ever used it was on 12/28/23 when he swung it at Resident #1.
-He would make another one, if necessary, as there were plenty of rocks outside and he had plenty of socks.

Interview with the Dietary Supervisor on 01/04/24 at 10:42am revealed:
-He was in the kitchen when an altercation occurred outside the dining room.
-Resident #3 and Resident #1 were having a verbal altercation.
-He requested Resident #1 go down the hall so the two of them could separate and simmer down.
-A few minutes later Resident #1 returned and by then Resident #3 had a sock with something in it and he was swinging it around, but it did not hit Resident #1.
-Someone yelled for him to grab the sock, so he did, because he realized it was a weapon.
-He took the sock to the medication room, and he put it on the counter.
-The Resident Care Coordinator (RCC) was informed about the incident.
-He had never seen the sock before.

Interview with the RCC on 01/05/24 at 10:32am revealed:
-Resident #3 and Resident #1 were arguing in the hallway near the dining room about 7-10 days ago when Resident #3 pulled out a sock with a

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D 456	Continued From page 26 rock in it and started to swing it at Resident #1. -She did not personally see the incident, but she was present in the building. -She was told Resident #1 was not hit. -She thought another resident took the sock away from Resident #3. -Whoever took the sock away from Resident #3 put it in the medication room up on a shelf and the last she heard someone was going to take it to the OM. -She had never seen Resident #3 with a sock or a rock before. -She had never seen Resident #3 and Resident #1 argue before. -She never saw Resident #3 angry or lash out at anyone ever before. -She did not take the sock off the shelf and inspect the rock and she did not know if any other staff looked at it either. Attempted review of Resident #3's accident incident report for 12/28/23 revealed no report was completed. Interview with the OM on 01/05/24 at 11:39am and 1/09/24 at 6:58am revealed: -She was not present when Resident #3 had an altercation with Resident #1 outside the dining room on 12/28/23. -She was informed Resident #3 started swinging a sock with a rock in it at Resident #1, trying to intimidate him. -Staff intervened and took the sock away and the two were redirected. -Resident #3 told her he swung the sock with the rock in it was because he was in a wheelchair and needed to defend himself. -Staff reported to her that they suspected Resident #3 had a rock or was collecting rocks, but nothing had ever been seen on him before	D 456		

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	HAL059021	A. BUILDING: ____ B. WING ____	01/26/2024

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that day.
-When there was a physical altercation between residents, staff were trained to redirect the residents or call mobile crisis if they can't be redirected or calmed down.
-LLE was called if the resident was unable to calm down or if the resident requested LLE become involved.
-LLE was not contacted very frequently at the facility, usually just for an involuntary commitment.
-Staff had been trained in the policy regarding how to handle challenging behaviors.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 01/09/24 at 12:48pm revealed:
-He was informed about the 12/28/23 incident between Resident #3 and #1 on 01/04/24 when he was at the facility.
-Resident #3 was not known to be violent.
-He did not provide psychiatric care for residents at the facility.

Telephone interview with Resident #3's guardian on 01/05/24 at 2:08pm revealed:
-He came to the facility monthly.
-He was not informed of any aggressive behaviors that Resident #3 displayed.

Review of the 911 call report revealed 911 was not called at the time of the incident on 12/28/23.

Review of the pictures of the sock and a rock revealed:
-The rock was rectangular shaped, about the size of an adult hand.
-The sock was a long, thick athletic sock.

Refer to Telephone interview with a Detective

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D 456	Continued From page 28 from LLE on 01/12/224 at 2:51pm. Refer to interview with the Administrator on 01/11/24 at 4:16pm. b. Review of Resident #1's current FL2 dated 04/06/23 revealed: -Diagnoses included epilepsy and history of alcohol abuse. -Resident #1 was oriented and ambulatory with no assistive device. Interview with Resident #1 on 01/04/24 at 10:03am revealed: -About one week ago Resident #3 was leaving the dining room and he pulled out a sock that had something in it and started swinging it. -He blocked it, so he was never hit or hurt. -An employee from the kitchen intervened and took the sock away from Resident #3. -He had never seen the sock before that day. Interview with the Dietary Supervisor on 01/04/24 at 10:41am revealed: -He heard two residents "exchanging words" in the hallway. -He saw Resident #1 slinging a sock with an unidentified object inside. -He was able to grab the sock and take it from Resident #3. -Resident #3 was "upset" that he took the sock away from him. Review of Resident #1's accident report dated 12/28/23 revealed: -Resident #3 and Resident #1 were "involved in verbal altercation." -The incident occurred in the hallway at 1:00pm on 12/28/23. -The two residents were "redirected without	D 456		

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further incident."
-Resident #1 said Resident #4 was "running his mouth."
-There was no injury present to Resident #1.

Review of the charting notes for Resident #1 dated 12/28/23 revealed "resident involved in verbal altercation with another resident, both redirected without further incident."

Interview with the RCC on 01/05/24 at 10:32am revealed:
-Resident #3 and Resident #1 were arguing outside the dining room about 7-10 days ago when Resident #3 pulled out a sock with a rock in it and started to swing it around.
-She did not personally see the incident.
-She was told Resident #1 was not hit.
-She thought another resident took the sock away from Resident #3.
-Whoever took the sock away from Resident #3 put it in the medication room up on a shelf.
-She had never seen the sock before.
-She had never seen Resident #3 angry before.
-She did not look at or inspect the rock.
-She was unaware of any incident prior to 12/28/23 where the other resident had a rock in a sock threatening residents.

Interview with the OM on 01/05/24 at 11:42am revealed:
-She was not present in the facility when the incident occurred on 12/28/23.
-She heard there was a verbal altercation between Resident #1 and Resident #3 on 12/28/23.
-The staff reported Resident #1 had a sock with a rock in it.
-Staff intervened and took the sock with the rock in it from Resident #1.

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-Resident #3 was "not typically violent in any way."
-The two residents were easily redirected so law enforcement was not contacted.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 01/09/24 at 12:48pm revealed:
-He was informed about the 12/28/23 incident involving Resident #1 on 01/04/24 when he was at the facility.
-Resident #3 was not known to be violent.
-He did not provide psychiatric care for residents at the facility.

Review of the 911 call report revealed 911 was not called at the time of the incident on 12/28/23.

Refer to interview with the Administrator on 01/11/24 at 4:16pm.

Refer to Telephone interview with a Detective from LLE on 01/12/224 at 2:51pm.

3. Review of Resident #3's current FL2 dated 02/07/23 revealed:
-Diagnoses included dementia with behavior disturbances and history of traumatic brain injury.
-Resident #3 used a wheelchair for ambulation.

Interview with a medication aide (MA) on 01/09/24 at 6:26am revealed:
-Resident #3 came outside onto the smoking patio after breakfast on 12/23/23 where she and a personal care aide (PCA) were smoking, and Resident #3 was being verbally aggressive, cursing and yelling.
-Resident #3 started swinging a sock around that contained a large rock and threatened to hit his roommate and anyone that was getting on his

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D 456	Continued From page 31 nerves and running their mouth. -The employee that was working with her on the morning of 12/23/23 took the sock with a rock in it away from Resident #3 and placed it in a plastic icing container where only that employee could find it. -She refused to identify the name of the employee who took the sock away from Resident #3. -If a resident hit another resident she would complete an incident report, a shift report and verbally report the incident to the OM and the RCC. -She reported the incident to the 2nd shift MA at the end of her shift. -She did not complete an incident report because she "I had to keep the 67 residents safe" and "I'm only one person". Interview with a PCA on 01/11/24 at 2:53pm revealed: -She was working on the morning of 12/23/23. -The MA told her about the rock in a sock incident in the smoking area a few weeks ago with Resident #3, but it did not occur on 12/23/23; she was told it happened several weeks prior to that date. Interview with the OM on 01/09/24 at 6:58am and 01/10/24 at 9:30am revealed: -Staff were responsible to report to management any incidents that occur at the facility. -She was the 2nd shift MA that worked on 12/23/23 and the incident with Resident #3 in the smoking area on 12/23/23 was never reported to her. Refer to Telephone interview with a Detective from LLE on 01/12/224 at 2:51pm.	D 456		

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Refer to interview with the Administrator on 01/11/24 at 4:16pm.

____

Telephone interview with a Detective from LLE on 01/12/224 at 2:51pm revealed:
-The facility should contact LLE any time there was an assault.
-Assaults could be classified as either physical or verbal.
-If someone verbally threatened another person it may be considered an assault.
-LLE should definitely be contacted if a physical assault resulted in injury.
-If a resident informed the staff at the facility that they did not want to press charges, it should be documented but staff should still contact LLE so the incident could be documented, and LLE could determine if it needed to be investigated.

Interview with the Administrator on 01/11/24 at 4:16pm revealed:
-All staff were trained to report any accident or incident to their shift Supervisor.
-She expected the Supervisor to write an accident/incident report for all reported accidents and incidents and give it to the Operations Manager.
-Staff were trained to call LLE if a resident refused to calm down after an incident or if a resident requested LLE be called.
-Staff did not call LLE unless there was a serious injury.

____

The facility failed to report an incident involving a physical assault to Local Law Enforcement after Resident #4 assaulted Resident #2, resulting in a black eye; an attempted assault when Resident #3 was swinging a sock around that contained a large rock and attempted to hit Resident #1; and verbal aggressions with threats of physical harm

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D 456	Continued From page 33 when Resident #3 was swinging a sock containing a large rock threatening to hit anyone that was aggravating him. This failure resulted in serious neglect and constitutes a Type A1 Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	D 456		