Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Pinebrook Residential Center II
Address: 309 Harrison Ave, Yadkinville, NC 27055
II. Date(s) of Visit(s): 07/17/25,07/22/25,07/23/25,07/24/25

County: Yadkin
License Number: HAL099016
Purpose of Visit(s): Follow-Up
Exit/Report Date: 07/24/25

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column III (c), indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0909	☒ POC Accepted SUC *DSS Initials*	—
Rule/Statutory Reference: 10A NCAC 13F .0909 Resident Right's An adult care home shall assure that the rights of all residents are guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. Level of Non-Compliance: Type A1 Findings: Based on observation, interviews and record reviews, the facility failed to ensure all residents were treated with dignity and respect, and were free from physical and verbal abuse by a staff (Staff A) who struck a resident (#3) with a rubber band on his back while out in the rain causing the resident to feel angry and unsafe.	See attached	

The findings are:

Review of Resident #3's FL2 dated 06/26/25 revealed:
-Diagnoses including Diabetes, Bipolar Disorder, and Traumatic Brain Injury.
-He was intermittently disoriented.
-He was semi ambulatory and required the assistance of a wheelchair.

Review of Resident #3's Progress Notes dated 07/13/25 revealed:
-Resident #3 was observed on the women's hall demanding to use a staff members' cellular phone.
-Resident #3 was witnessed calling staff obscene names and making inappropriate comments.
-A staff member attempted to assist Resident #3 with his wheelchair in moving him back to the men's hall but Resident #3 was non-compliant.
-Resident #3's wheelchair was broken and he was provided a cane.

Interview with Resident #3 on 07/17/25 at 1:54pm revealed:
-He frequently had arguments with Staff A who would yell at, make fun of, and refuse to help him.
-While asking to use another staff members' phone Staff A dragged him outside in the rain, popped him in the back with a rubber band, and broke the wheel and armrest of his wheelchair while trying to drag him across the parking lot toward the other facility entrance.
-He had to go a number of days without his wheelchair due to it being broken by Staff A.
-This was not the first time Staff A had been verbally or physically aggressive towards him.
-He remembered a time Staff A saw him lying on the floor in the bathroom after he had fallen but Staff A refused to assist him back into his wheelchair, and left the resident to lift himself off the ground.
-He felt angry that Staff A treated him differently, and felt unsafe in the facility whenever he was on shift.
-He never reported the incident because he didn't believe anyone would do anything to help him.

Observation of Resident #3's wheelchair on 07/17/25 at 1:54 pm revealed:
-The left armrest of Resident #3's wheelchair was broken and the rubber tread on the wheel was missing.

Interview with Staff A on 07/17/24 at 4:12pm revealed:

-He was aware of an incident between him and Resident #3. -He attempted to assist Resident #3 back to his room because the resident was being rude to staff. -Resident #3 had come to the medication room demanding to use a staff members phone and when he was denied the resident began to curse, scream, and he made sexual comments to the other staff members. -He called the resident care coordinator and she instructed him to move Resident #3 back to his room. -He attempted to move Resident #3 to his room but the resident had locked the wheels of his wheelchair while they were outside in the rain and refused to be moved further. -Resident #3's wheelchair was broken in the process. -He gave Resident #3 a cane to use while he attempted to fix the resident's wheelchair. Review of facility camera footage dated 07/13/25 revealed: -At 6:43pm Staff A was seen entering the medication room and popping another staff member in the back with a rubber band. - At 6:46pm Resident #3 was seen at the door of the medication room talking to a staff member. -At 6:47pm Staff A walked out of the medication room and closed the door behind him. -Another staff member walked out of the medication room and was seen watching Staff A and Resident #3 talking in the hallway. -At 6:49pm Staff A was seen wheeling Resident #3 down the hallway and outside where it was raining. -Resident #3 was seen attempting to put down the brakes on his wheelchair. -Staff was seen pulling Resident #3's wheelchair forcefully in the parking lot. -Staff A and Resident #3 were seen talking aggressively to one another. -At 7:00pm Staff A was seen standing behind Resident #3. -Staff A pulled out a rubber band and popped Resident #3 on the back with the rubber band. Interview with a resident on 07/17/25 at 2:10pm revealed: -She witnessed Staff A drag Resident #3 outside in the rain while in his wheelchair. -She remembered seeing Resident #3's wheelchair was broken after the incident. -She observed Staff A being rude and unkind to Resident #3 on multiple occasions. -She had previously heard Staff A yell at Resident #3 in the dining room that he was not allowed to have second helpings of food at dinner time due to Resident #3 "[expletive] on		

himself if he eats too much", loud enough for other residents to hear. Interview with a second resident on 07/24/25 at 11:34pm revealed: -Staff A had frequently picked at him and made comments about his religion in an attempt to make him angry. -Staff A would come into the resident's room and state " ain't no such thing as the devil [expletive]". -He was angry when Staff A spoke to him this way and he punched a wall to keep from punching the staff member. -He felt angry and unsafe when Staff A was in the facility. -He had informed the Resident Care Coordinator (RCC) of the incident with Staff A. -The RCC told Staff A not to talk to the resident. Interview with a third resident on 07/24/25 at 12:05pm revealed: -He witnessed Staff A scream at Resident #3 for urinating in the dining room. -Staff A forced Resident #3 to eat on the patio due to being incontinent for all meals after the incident. -He recalled Staff A screaming at him multiple times since he had been at the facility. -He recalled an incident when he had been late to the dining room for lunch and Staff A screamed at him stating "I will take you down the street and beat your [expletive]". -He felt unsafe, vulnerable, and upset when Staff A yelled at him. -He had not reported Staff A yelling at him to the administration because he did not believe anyone would do anything about it. Interview with a personal care aide (PCA) on 07/22/25 at 2:45pm revealed: -She had witnessed an incident concerning Resident #3 and Staff A. -Resident #3 came into the medication room while two other PCA and a medication aide (MA) were present and asked to use another PCA's cellular phone but was denied. -Resident #3 cursed and screamed at the PCA after which Staff A exited the medication room and began to argue with Resident #3 in the hallway. -Staff A called the RCC and asked what to do about Resident #3, the RCC stated "get the resident off the hallway". -She witnessed Staff A wheel Resident #3 down the hall, take him outside of the facility while it rained, and popped the resident with a rubber band.		

-She had not witnessed Staff A break Resident #3's wheelchair. Interview with PCA on 07/22/25 at 4:10pm revealed: -She had witnessed an incident concerning Resident #3 and Staff A. -She was in the medication room with another PCA, Staff A and a MA when Resident #3 asked to use her cellular phone. -Resident #3 began to curse and scream at her when she declined to let him use her cellular phone. -Staff A walked out of the medication room and closed the door and she exited the room shortly after. -She witnessed Staff A call the RCC who told Staff A to take Resident #3 to the other hall. -She heard Staff A state to Resident #3 "meet me out by the stop sign, I will beat your [expletive]". -She witnessed Staff A pulling Resident #3 while in his wheelchair outside in the rain. -She witnessed Staff A pulling Resident #3 hard enough to break the wheelchair. -She witnessed Staff A pop Resident #3 in the back with a rubber band while they were outside in the rain. -Staff A was known to be mean to residents. -She had heard Staff A call another resident stupid and ugly on multiple occasions. -She had informed the RCC and the Operations Manager (OM) about Staff A's treatment of residents. Interview with the Administrator on 07/22/25 at 4:45pm revealed: -She had confirmed physical abuse of Resident #3 by Staff A through facility camera footage and by an internal investigation. -She had obtained information that the RCC had told a PCA not to inform the adult home specialist of events that occurred between Resident #3 and Staff A. -Staff A and the RCC were suspended pending an investigation. -She had begun a report to the health care personnel registry. -She had not been made aware of any physical abuse by any staff or residents. Interview with a housekeeping staff on 07/23/25 at 11:45am revealed: -She recalled an incident when Resident #3 had fallen to the floor after he showered. -She was not allowed to assist residents due to not being a clinical staff member.		

-She notified Staff A that Resident #3 had fallen and needed assistance. -Staff A went to the bathroom where Resident #3 had fallen but did not assist him up. -She saw Resident #3 have to pull himself up off the floor without help. -She felt that Staff A should have helped Resident #3 up but she did not notify another staff of the incident. -A maintenance staff member also witnessed this incident. Interview with the OM on 07/17/25 at 3:43pm revealed: -She was aware of an incident concerning Staff A and Resident #3. -She was not present during the incident. -The RCC reported to her that Resident #3 had asked to use a staff member's cellular phone but became angry when denied. -The RCC instructed Staff A to take Resident #3 back to his room but the resident was non-compliant and locked the wheels of his wheelchair while Staff A was wheeling him which caused the wheelchair to break. Second interview with the Administrator on 07/24/25 at 3:20pm revealed: -Prior to notification from the Adult Home Specialist she was unaware of an incident between Staff A and Resident #3. -No staff had informed her of Staff A's mistreatment of Resident #3. -No residents had informed her of mistreatment by Resident #3. Interview with Resident #3's mental health provider on 07/23/25 at 2:45pm revealed: -Resident #3 had verbalized negative treatment from Staff A. -Several residents had spoken to her about Staff A's negative treatment of them. -Several residents had reported to her that Staff A had been mean and aggressive to them, bullied them, and would sometimes withhold food and other personal items to get residents to do what he wanted. -Several residents verbalized they felt unsafe or uncomfortable around Staff A. -One resident verbalized feeling anxious and agitated due to Staff A picking on him. -The facility's primary care provider (PCP) had previously brought to her attention the concerns of residents' feelings about Staff A. -She had previously brought her concerns about Staff A to the OM.		

Interview with Resident #3's PCP on 07/24/25 at 12:07pm revealed:
-Resident #3 had brought concerns to her about being mistreated but she had not relayed those concerns to the administration.
-One other resident had previously brought concerns about feeling unsafe and threatened by Staff A being verbally abusive to him.
-She had previously relayed concerns about resident's concerns about Staff A to the facility Mental Health Provider.

Interview with the RCC on 07/17/25 at 4:35pm revealed:
-She was aware of an incident concerning Staff A and Resident #3 but had not witnessed it.
-She was told by Staff A that Resident #3 was angry about not being able to use a staff member's cellular phone.
-Staff A had called her that day and asked what to do about Resident #3 to which she responded to take the resident back to the men's hall.
-She was informed that Staff A attempted to move Resident #3 but he was non-compliant and that another staff member had to take over.
-She had not heard any resident make complaints about negative treatment from Staff A.

Attempted interview with maintenance staff on 07/23/24 at 12:25pm was unsuccessful.

The facility failed to ensure residents were free from physical and mental abuse and were treated with dignity and respect when staff (Staff A) struck a resident (#3) in the back with a rubber band resulting in the resident feeling angry and unsafe: and residents were treated with dignity and respect by being screamed, cursed at, and threatened by Staff A resulting in residents feeling uncomfortable and unsafe. This failure resulted in the physical abuse of one resident (#3) and verbal abuse of other residents which constitutes a Type A1 violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 07/22/25 for this violation.

CORRECTION DATE FOR THE TYPE A1 VILATION SHALL NOT EXCEED, AUGUST 22ND, 2025.

IV. Delivered Via:	Hand Delivered	Date: 08/06/2025
DSS Signature:	[signature] /SUS III	Return to DSS By: 08/23/25

V. CAR Received by:	Administrator/Designee (print name): Kristi Evans	
	Signature: [signature]	Date: 8/6/25
	Title: Operations Specialist	

VI. Plan of Correction Submitted by:	Administrator (print name): Danny Boone	
	Signature: [signature]	Date: 8/2/25

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☒ ***POC Accepted***	By: [signature] /SUS III	Date: 08/21/2025
Comments: YCHSA Accepted facility POC as written. POC was submitted via email.		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:
Comments:			

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*

Facility Response to Statement of Deficiencies

Resident Rights Affirmation
The facility affirms the rights of residents under N.C. General Statute 131D-21 (Resident's Bill of Rights) and confirms that these rights are exercised without hindrance. Residents are entitled to be treated with dignity and respect and to be free from physical and verbal abuse.

As cited in the Statement of Deficiency:

"Based on observation, interviews, and record reviews, the facility failed to ensure all residents were treated with dignity and respect and were free from physical and verbal abuse by staff who struck a resident with a rubber band on his back while out in the rain, causing the resident to feel angry and unsafe."

Corrective Actions Taken

Immediate Protective Action
The staff member involved was immediately suspended and removed from resident care responsibilities.

Local law enforcement was contacted, and the facility fully cooperated with their investigation.

A report was made to the Health Care Personnel Registry within 24 hours, and the required 5-day working report was submitted.

Resident Protection and Placement
The resident involved was assessed, supported, and the facility later arranged his transfer to another appropriate placement, with the agreement of his guardian. This was done to better meet his needs and to assure his ongoing sense of safety.

It is important to recognize that this resident presented significant challenges in his care and interactions within the facility. Documented records reflect repeated incidents of inappropriate and disruptive behavior. These included urinating in public areas of the facility and on the grounds, as well as masturbating both indoors and outdoors. On multiple occasions he approached female residents and staff to solicit sexual favors. Staff documented an incident at the designated smoking area where he had to be asked to stop performing a sexual act.

In addition to these sexual behaviors, the resident was verbally abusive to staff and peers, often using intimidating and offensive language. He exhibited bullying tendencies, frequently instigating arguments between residents, then inserting himself into the conflict. On one documented occasion, he escalated such a situation by physically hitting another resident. These patterns of behavior created distress and

disruption for both staff and fellow residents and required continual monitoring and intervention.

Although the resident had a history of mental illness, he was cognitively able to understand his actions and the effect they had on others. His behaviors were intentional and purposeful, not simply automatic, and he made conscious choices to act inappropriately. The resident's guardian was fully aware of these behaviors and understood the steps the facility was taking to help the resident better control his actions and make more appropriate choices, based on the advice and guidance provided by his physicians and therapist.

Despite these difficulties, facility management was actively working with the resident's primary care physician, psychotropic medication physician, and therapist to help him manage his behaviors. Some headway was being made through these efforts, but progress was slow and the challenges remained significant. These circumstances underscore the complexity of his care and the daily strain placed on staff.

However, while these facts provide important context, they do not excuse the illegal and unacceptable act committed by the employee in this incident. The facility responded immediately to protect residents, hold staff accountable, and reinforce its zero-tolerance policy for any form of abuse.

Staff Investigation and Accountability
During the investigation, it was discovered that an RCC attempted to discourage staff with written texts from reporting the incident to management. This was immediately reported to the police who investigated the incident and the facility addressed with the following actions:

- The RCC was terminated for cause, and her involvement was specifically included in the submission to the Health Care Personnel Registry.
- Any staff who knew or heard of the incident and failed to report were issued written warnings. Issuing written warnings causes a staff to lose any incentive wages for at least two weeks.
- One staff member already on prior written warning for failing to report a different incident was terminated.

Re-Training and Systemic Prevention
All employees were required to re-review and re-sign the Employee Responsibility to Report Policy, which provides direct contact numbers for the Administrator, Operations Manager, Executive Vice President, COO, and CEO, as well as an independent third-party hotline number.

Facility executives personally reviewed this policy with staff and emphasized their duty to report immediately.

An outside state-approved consultant provided training on abuse prevention, resident rights, and staff reporting obligations. Two separate training courses were completed, including participation by the local Ombudsman. Additional training is scheduled with mental health professionals to better equip staff to manage the challenging behaviors of residents with historical mental illness and to reinforce strategies for not internalizing or taking those actions personally.

Systemic Measures Implemented
The facility has established and re-communicated a zero-tolerance stance toward any form of abuse or intimidation.

Reporting mechanisms have been expanded and staff is reminded in writing, in meetings, and through posted notices of their duty to report to management or the independent hotline.

The Executive Team will continue quarterly staff training on resident rights and mandatory reporting requirements, with attendance documented.

Conclusion
The facility deeply regrets that this incident occurred. While no policy or training can entirely prevent the illegal acts of others, the facility acted immediately and decisively to protect residents, terminate the employees responsible, involve law enforcement, and strengthen our systems to prevent recurrence. We remain fully committed to ensuring that all residents are treated with dignity and respect and are free from abuse.
Correction date August 7, 2025.