

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 survey and complaint investigation from November 9, 2015 to November 13, 2015 and November 16, 2015 to November 19, 2015 with a telephone exit on November 30, 2015.	D 000		
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305Physical Environment (d) The requirements for the bedroom are: (1) The number of resident beds set up shall not exceed the licensed capacity of the facility; (2) There shall be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, any live-in staff and other persons living in the home. Residents shall not share bedrooms with staff or other live-in non-residents; (3) Only rooms authorized as bedrooms shall be used for residents' bedrooms; (4) Bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom; (5) There shall be a minimum area of 100 square feet excluding vestibule, closet or wardrobe space in rooms occupied by one person and a minimum area of 80 square feet per bed, excluding vestibule, closet or wardrobe space, in rooms occupied by two people; (6) The total number of residents assigned to a bedroom shall not exceed the number authorized for that particular bedroom; (7) A bedroom may not be occupied by more than two residents. (8) Resident bedrooms shall be designed to accommodate all required furnishings; (9) Each resident bedroom shall be ventilated	D 049		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

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D 049	<p>Continued From page 1</p> <p>with one or more windows which are maintained operable and well lighted. The window area shall be equivalent to at least eight percent of the floor space and be provided with insect screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and</p> <p>(10) Bedroom closets or wardrobes shall be large enough to provide each resident with a minimum of 48 cubic feet of clothing storage space (approximately two feet deep by three feet wide by eight feet high) of which at least one-half shall be for hanging clothes with an adjustable height hanging bar.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure 13 window screens provided for resident bedroom and bathroom windows were installed or free from defect.</p> <p>The findings are:</p> <p>Observations of the exterior of the facility on 11/13/15 between 10:00am and 10:45am revealed:</p> <ul style="list-style-type: none"> -The 100 Hall bathroom had no screen. -Room 107 window had no screen. -Room 201 had broken screens with screen material out of frame. -Room 205 had no screen. -Room 207 had no window screens. -Room 211 had loose screens. -Room 409 screen was bent, out of square and not fastened securely. -Room 410 bathroom had screen on the ground and the window was open. -Room 408, the right screen was missing. 	D 049		

Division of Health Service Regulation

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D 049	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Room 406 had a loose screen. -Room 404 had broken window glass both upper and lower panes and crack taped with duct tape. -"Sherry's bathroom" had a broken screen loose at the bottom. -Room 308 bathroom had a 2" x 2" L-shaped tear in the screening material that was pushed outward. <p>Interview with the Maintenance Supervisor on 11/11/15 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - He made replacement screens for windows. - If screens were missing, "99%" of them were due to residents smoking in rooms. - Regarding screens in bathrooms, "we have some peeping toms" who had been known to remove screens to move curtains for a "look in." <p>Additional interview with the Maintenance Supervisor on 11/13/15 at 10:20am revealed:</p> <ul style="list-style-type: none"> -The residents who smoke in their rooms push out the screens and damage them as soon as he replaced them. -He stopped replacing some of the screens because they were too frequently damaged. -He occasionally received maintenance request forms from staff but not usually. -He has found screens on the ground all the time. <p>Observation and interview with the Maintenance Supervisor on 11/18/15 at 10:20am revealed:</p> <ul style="list-style-type: none"> -He was replacing a screen on the 100 Hall bathroom. -"It might stay there one night before (Resident's name) kicks it out. -If they lock the windows, (Resident's name) kicks it out because he thinks the dayroom is his bedroom." <p>Interview on 11/19/15 at 9:40am with the</p>	D 049		

Division of Health Service Regulation

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D 049	Continued From page 3 Operations Manager revealed: -Maintenance oversight was being transitioned to the Assistant Operations Manager. -At least once per month she went around the building, inside and out and created a list of maintenance and housekeeping issues. -The list was prioritized, distributed to and reviewed with the maintenance staff and the Assistant Operations Manager who supervised the housekeeping staff. - "Anything safety related " would receive highest priority. -The maintenance issues which occurred on a daily basis are addressed by the maintenance staff. He would have documentation of those issues. -There was one maintenance person for the building. -There had been occasions when outside contractors were hired to complete a job, such as the recent re-tiling of one of the common bathrooms. The maintenance staff knew his limitations and would inform her when a task was beyond his skill set. -There was no formal follow-up process since staff are interacting with one another on a daily basis." -She would review the list when she completed the next walk about the building.	D 049		
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting	D 072		

Division of Health Service Regulation

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D 072	<p>Continued From page 4</p> <p>or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: Based on observations the facility failed to assure the exterior grounds were kept in a clean and orderly condition as evidenced by trash thrown over the fence at the 400 Hall smoking area and around the building.</p> <p>The findings are:</p> <p>Observation on 11/9/15 at 2:55pm of the side of the building facing the road revealed: -The gutters were filled with debris and pine needles, visible when standing on the ground. -It was raining and there was a steady flow of water coming over the top of the gutter.</p> <p>Observation on 11/18/15 at 10:20am of the backside of the building that faced the wooded area revealed the gutters were filled with debris and pine needles and visible when standing on the ground.</p> <p>Interview on 11/18/15 at 10:20am with the Maintenance Supervisor revealed: -He cleaned the gutters twice per year. -This time of year he waited for all of the leaves to drop from the trees before cleaning them out.</p> <p>Observation on 11/11/15 at 11:40am of the vicinity of the smoking area behind the dining room revealed: -9 black trash bags sitting against a chain link fence. -Insects were flying over the trash bags.</p>	D 072		

Division of Health Service Regulation

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D 072	<p>Continued From page 5</p> <p>Observations of the exterior of the facility on 11/13/15 between 10:00am and 10:45am revealed:</p> <ul style="list-style-type: none"> -There were numerous cigarette butts all around the building. -There were three broken screens leaning up against the Maintenance building front wall, with loose board and debris scattered around the ground. The walk way to the door was comprised of loose, damaged shingles laid on the ground along with pieces of weathered rotting plywood. -There was a sawhorse, worktable and pieces of loose screen framing material in front of the maintenance building. -An uncovered mattress laying on the ground at the end of the maintenance building, along with a metal base, plastic 5-gallon bucket filled with debris, and a piece of plastic covering a home made work table. -A damaged chair with plastic back and seat outside of the exterior kitchen wall. -There were empty plastic cans, aerosol cans, plastic drink bottles, aluminum drink cans, clothing, coffee cans, large food cans, black plastic trash bags, empty chips/snack packages, deteriorating cardboard boxes and styrofoam drink cups littering the outside perimeter fence line near the 400 Hall smoking area. <p>Interview on 11/11/15 11:45am with a Housekeeper (in the vicinity of the bagged cans) revealed:</p> <ul style="list-style-type: none"> -The bagged cans "more than likely" had been at the fence for "a few days." -In the past the facility would take the cans to a recycling center for money but not recently. <p>Interview on 11/11/15 at 11:40am with a resident revealed:</p> <ul style="list-style-type: none"> -She collected aluminum cans but did not get any 	D 072		

Division of Health Service Regulation

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D 072	<p>Continued From page 6</p> <p>of the money.</p> <p>-The cans were bagged up and placed behind the main building (she motioned to a place along a fence in the vicinity of the smoking area behind the dining room).</p> <p>Interview on 11/19/15 at 9:40am with the Operations Manager revealed:</p> <p>-Maintenance oversight was being transitioned to the Assistant Operations Manager.</p> <p>-At least once per month she went around the building, inside and out and created a list of maintenance and housekeeping issues.</p> <p>-The list was prioritized, distributed to and reviewed with the Maintenance Supervisor and the Assistant Operations Manager who supervised the housekeeping staff.</p> <p>- "Anything safety related" would receive highest priority.</p> <p>-The maintenance issues which occurred on a daily basis are addressed by the maintenance staff. He would have documentation of those issues.</p> <p>-There was one maintenance person for the building.</p> <p>-There was no formal follow-up process since staff are interacting with one another on a daily basis.</p> <p>-She would review the list when she completed the next walk about the building.</p>	D 072		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 7</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to make repairs to or maintain in clean condition floors, walls, ceilings, doors and light fixtures throughout the facility.</p> <p>The findings are:</p> <p>A. Observations on 11/9/15 from 10:55am to 4:15pm revealed:</p> <ul style="list-style-type: none"> -The Living Room on the 100 hallway had a urine odor in the corner of the room where an artificial potted plant was located. The floor under the potted plant had a yellow-brown stain surrounding the pot. -The Dining Room exit door had a gap between the door and the floor along the entire width of the door, the widest portion of the gap approximately 1 inches in the vicinity of the right door jamb. An approximately 2 inch diameter and ½ inch deep section of cement flooring was missing at the right door jamb, increasing the widest part of the gap between the door and the floor. Light from outside was visible through the gap between the door and the floor when it was closed. -The door to resident room #101 revealed the door sticking against the door jamb, requiring additional effort to open the door. -The medication room had numerous dead bugs in two ceiling fluorescent light fixture covers. -Resident room #105 had a polyvinyl chloride (PVC) pipe that entered the concrete block wall behind the headboard of the bed by the door and was surrounded by a rectangular piece of a flat painted product attached to the surrounding wall. Where the PVC pipe entered the wall, an approximate ½ inch gap surrounded the pipe (the flat painted product was not flushed or caulked to 	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 8</p> <p>the PVC pipe). Only one light bulb in the ceiling light was in working condition.</p> <p>-Resident room #107 had large patches of brown staining, repair patches not sanded and one place of peeling and bubbling paint on the ceiling. A broken plastic light cover on the wall light fixture over the bed with a piece of the cover missing. Only one of light bulbs in the ceiling light was working.</p> <p>Observations on 11/10/15 at 4:18pm and 4:20pm on the 400 hallway revealed:</p> <p>-An exit door to an outside sitting area.</p> <p>-An approximately ¼ inch gap at the bottom of the exit door with outside light visible when the door was closed.</p> <p>-The emergency exit sign over the door was not illuminated.</p> <p>Confidential interview with a resident revealed:</p> <p>-He did not know how long one of the two bulbs in his ceiling light fixture were blown out.</p> <p>-Staff had commented to the resident "how dark it is in the room."</p> <p>Review of the most recent Environmental Health Inspectors sanitation and building report dated 10/27/15 revealed a one point deduction for "floors clean, carpet clean, dry, odor free" with the additional comment "walls and ceilings to be in good repair, repair any holes in walls, repair/repaint rusted door frames."</p> <p>Review of an undated comment addendum form to the inspection report, provided by the facility, revealed the following instructions from the health inspector:</p> <p>-"Clean floors throughout- Clean underneath all patient beds- dust/debris buildup present."</p> <p>-"Clean window sills, repaint any rusty areas on</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 9</p> <p>door frames, vents, walls, etc." -"Clean all showers (floors, corners) clean base of all toilets in shared restrooms and patient bathrooms ..."</p> <p>Interview on 11/11/15 at 10:30am with a Housekeeping staff member revealed: -He mopped the floors 3-4 times a week. -Most rooms needed to be mopped daily because residents spilled or urinated on the floor. -He used a cleaning spray called "[brand name]" around the base of the toilets at night to control urine odor. -He did not know what caused the large black rings around some toilets and underneath the sinks.</p> <p>Interview on 11/11/15 at 12:15pm with the Maintenance staff member revealed: -He was a "one person shop" but sometimes outside assistance was hired for specialty jobs like tiling. -Regarding the Fire Marshal report, the exit door in the dining room received "a lot of abuse" from residents in the past and was not closing right but it was now closing. -He took notes when the Fire Marshall was in the facility, his leadership did not provide a copy of the report but they gave him a "list of things" that needed attention. -He was aware of some repairs required on ceilings and walls but his issue was "it's getting time to do stuff." -Housekeeping staff were expected to give him a list of things "wrong"as he did not personally go into rooms every day. -Cleaning of "some" of the overhead vent covers is the responsibility of housekeeping staff while others, like the exhaust fan in the kitchen is managed by Maintenance.</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 10</p> <p>Observations on 11/11/15 at 4:35pm of the shared bathroom of rooms #205 and #207 revealed a heavily rusted metal door frame between the bathroom and room #205. The bathroom floor between the door frame and the commode was wet.</p> <p>Observation on 11/12/15 from 7:25am to 10:50am revealed:</p> <ul style="list-style-type: none"> -The doorframe to room #404 revealed an approximate 2 foot long area of missing paint peeled away from the left part of the doorframe. -The hallway ceiling outside room #408 had brown splatters and stains on the ceiling. -A large dried brown spot on the plastic cover of a florescent light fixture. -Room #210 there were missing floor tiles on both sides of the entry way door. A large area on an unpainted brick wall with white staining starting at the top near the ceiling. A brown stain along the drywall seam in the ceiling. Grey staining along the junction of the brick wall and ceiling. Black/grey staining in the corner of the dry wall ceiling in the closet, with a portion of the drywall pulling away from the ceiling. <p>Interview on 11/12/15 at 10:50am with the resident of room #210 revealed:</p> <ul style="list-style-type: none"> -When it last rained water "poured down" her brick wall. -Her clothes in her closet "got wet" as well, but they were washed in the laundry and placed in a plastic bin on the shelf. <p>Follow up observation on 11/19/15 at 7:54am of room #210 revealed:</p> <ul style="list-style-type: none"> -The brick on the interior partition wall that divided room #210 from the adjacent room appeared damp from the ceiling downward for about 20 	D 074		

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D 074	<p>Continued From page 11</p> <p>inches the entire length of the brick wall.</p> <p>-Puddled water (about ¼ inch deep) on the floor against the interior brick wall which extended from the brick wall for approximately 15 inches into the room; the puddle started about 24 inches from the closet wall and extended along the wall into the closet.</p> <p>Observations on 11/13/15 from 10:04am to 11:30am revealed:</p> <p>-Room #204 had a blackened floor around the base of the toilet bowl. A broken plastic ceiling light fixture in the bathroom.</p> <p>-Missing and broken baseboard at the 100 Hall entrance/exit door. An 1/4 to 1/2 inch gap at the bottom of the door. The doorframe paint chipped and peeled with large and small areas of black marks.</p> <p>-Cracked and missing baseboard tile between the 200 Hall and the dayroom.</p> <p>-The floor outside the staff break room had a large non-circular patched dark area of missing floor tile.</p> <p>-The 300 Hall bathroom toilet base was cracked and leaking. The floor around the toilet was stained with various sizes of black and brown stains. The tile floor in front of the toilet was cracked from wall to wall. The bathroom metal doorframe was rusted from the floor to 1 1/2 to 2 feet up the opening. The doorframe had broken and missing baseboard tile.</p> <p>-The shower room had various sizes of black and brown stains on the floor.</p> <p>-The 300 Hall smoking area exit door was missing the light bulb in the light fixture.</p> <p>-The 400 Hall smoking area had various sizes of black marks on the outside of the building next to the entrance/exit door from cigarettes being snuffed out.</p>	D 074		

Division of Health Service Regulation

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D 074	<p>Continued From page 12</p> <p>Interview on 11/18/15 at 5:15pm with the Assistant Operations Manager revealed:</p> <ul style="list-style-type: none"> -He supervised Housekeeping staff and was transitioning into being Maintenance Supervisor. -At that time he had not started directly supervising the Maintenance staff on a day to day basis. -There was one Maintenance staff person. -For the past 2 months he assisted the Maintenance staff person on "special projects." - A Housekeeping staff person was scheduled to address and remove the black stains on bathroom floors as soon as the cleaning product was delivered. -The Housekeeping Supervisor wet-mopped the floors daily. <p>Interview with the Operations Manager on 11/19/15 at 9:40am revealed:</p> <ul style="list-style-type: none"> -Maintenance oversight was being transitioned to the Assistant Operations Manager. -At least once per month she went around the building, inside and out and created a list of maintenance and housekeeping issues. -The list was prioritized, distributed to and reviewed with the Maintenance staff and the Assistant Operations Manager who supervised the Housekeeping staff. -The last time the list was done was on 10/29/15. -"Anything safety related" would receive highest priority. -The maintenance issues that occurred on a daily basis were addressed by the Maintenance staff who would have documentation of those issues. -There was one Maintenance person for the building. -There had been occasions when outside contractors were hired to complete a job, such as the recent retiling of one of the common bathrooms. The Maintenance staff person knew 	D 074		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 074	<p>Continued From page 13</p> <p>his limitations and would inform her when a task was beyond his skill set.</p> <p>-There was no formal follow-up process since staff are interacting with one another on a daily basis.</p> <p>-She would review the list when she completed the next walk about the building.</p> <p>Confidential phone interview with a resident's responsible person revealed her description of the facility as "disgusting" and "rooms are nasty."</p> <p>Refer to interview on 11/13/15 at 11:58am with the Housekeeping Supervisor.</p> <p>B. Observation on 11/09/15 from 10:40am to 12:40pm of the bathrooms in rooms #305, #306, #309, #405, #406, #407, and #410 (most rooms had adjoining rooms) during the initial tour of the facility revealed:</p> <p>-3 of the floors observed around the toilet was a black 3-inch wide ring extending around the toilet.</p> <p>-The same black marks were on the floor on the side of the toilet near the wall.</p> <p>-Black marks were behind the toilet, under the sink, and under the heating unit in the bathroom.</p> <p>-A black substance was also identified between cracks of the glass wall tile and the floor.</p> <p>-The black substance extended up the wall through of the cracks in the glass tile.</p> <p>-The entire bathroom water faucet was rusted and brown and bubbled in some areas. The top of the plastic handles had metal screws that were rusted and brown in color, and a brown substance that could not be identified.</p> <p>-The toilet seat, and inside the lid cover had black marks, and spots identified as cigarette burns.</p> <p>-There were dark brown and black marks on the floor around the door frame that extended up to 1 and ½ to 2 inches away from the metal door</p>	D 074		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 074	<p>Continued From page 14</p> <p>frame. The metal frame was painted white, and had rust spots, and chunks of paint scattered throughout the frame up to 2 feet from the floor. The bottom part of the inside door frame near the floor was rusted away with a 2 inch gap of missing metal. The outer part of the door frame was rusted away with up to 1 inch of missing metal.</p> <p>Review of the facility's "Building walk through" dated 10/29/15 revealed: -Room #306 had rusty door frame. -Room #309 bathroom was in need of repair. -No mention of the bathroom repairs for the 400 hall.</p> <p>Interviews with 2 responsible persons of residents that lived at the facility revealed: -When they visited there was always an odor coming from the bathroom. -The bathroom floor was disgusting, and she could not see where any cleaning had been done. -The facility was not fit for an "animal." -They was in the process of finding some place else for her person to live. -A second guardian revealed the cleanliness of the facility was questionable. -When they visited her resident's room was "trashy,"</p> <p>Interview on 11/11/15 at 10:30am with the Head Housekeeper revealed: -He mopped floors 3-4 times a week. -Some bathroom floors were mopped daily because residents spilled or urinated on the floor. -He was aware that some bathrooms had the black substance on the floor around the toilet, under the sink and heating units. -He did not know what the substance was, and thought the floors discolored.</p>	D 074		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 074	<p>Continued From page 15</p> <p>Second interview on 11/12/15 at 11:12am with the Housekeeper revealed: -He found out the floors with the black substance needed to be stripped. -He was told that stripper had been ordered and should be in any day. -He did not know when the stripper was ordered. -They think staff never went into the resident's room.</p> <p>Refer to interview on 11/13/15 at 11:58am with the Housekeeping Supervisor.</p> <hr/> <p>Interview on 11/13/15 at 11:58am with the Housekeeping Supervisor revealed: -Bathroom floors were cleaned daily, but they needed to be "grinded" to get up the black marks around the toilets, walls and heat registers. -The floors were concrete and grinding them will restore the floors the original color. -He was aware of the cleaning needed, but he did not have the finances to do "grinding" on the floors. -He had placed an order for stripper for the floors and it should be coming soon. -In a few months all bathrooms would be fixed.</p>	D 074		
D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 16</p> <p>hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, record reviews and interviews, the facility failed to correct multiple hazards, which include excessive clutter in 1 resident room (Room #200); for not using approved surge protection devices to prevent overloading of electrical outlets and having cracked outlet faceplates for 4 resident rooms (Rooms #105, #208, #303 and #410); for not effectively controlling for cockroaches throughout the facility and for not repairing a loose metal baseboard heater cover in 1 resident room (Room #105).</p> <p>The findings are:</p> <p>A. Observation on 11/12/15 at 2:15pm of room #200 revealed: -A stack of items approximately 3 feet high and 1 foot deep to the wall were noted immediately inside and to the right of the door frame. -A stack of items approximately 5 feet high were observed immediately to the left of the door frame, including a college dormitory-sized white refrigerator and box fan, which prevented the door from swinging all the way open. -A path, which exposed floor and measured from 1 to 2 feet wide, went from the door frame to a large green plastic container measuring approximately 2 feet wide by 3 feet long, the plastic container placed parallel to the bed (located against the wall where the window was</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 17</p> <p>located).</p> <ul style="list-style-type: none"> -The large green plastic container prevented direct and clear egress from the bed to the door, with a path circumscribing the plastic container approximately 1 foot wide. -Piles of clothes, plastic bags and stuffed animals lined the paths in the room. -A path, which exposed floor and measured from 1 to 2 feet wide, turned right inside the door and went to the bathroom, with piles of items on either side of the path. -The door to the bathroom was open, space surrounding the commode in the bathroom was taken by various items stacked approximately 5 to 6 feet up the walls. -Clothing hung along the top of the bathroom door. -A bureau approximately 5 to 6 feet long was pushed against a partially closed bi-fold closet door, with clothes pushing out of the drawers and with items (including a microwave) stacked on top of the bureau to the approximately 5 foot mark on the wall. <p>Interview on 11/12/15 at 3:00pm with a Housekeeper revealed:</p> <ul style="list-style-type: none"> -He was the "head" of cleaning rooms. -He would first "troubleshoot" rooms occupied by residents known to be "messy" or for those known to experience urine incontinence in bed, then proceed to cleaning other rooms. -He included room #200 in a group of those residents occupying single, private rooms, which were "checked daily." -"I have difficulty" keeping room #200 clean, describing it as "very cluttered" and the resident as not permitting housekeeping staff to enter the room. -The resident residing in room #200 "had lots of stuff." 	D 079		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 18</p> <p>-The resident residing in room #200 would ask Housekeeping staff for paper towels, toilet tissue and "sticky pads" for "catching insects and rodents," but it had "been a while" since she had "mice" in her room.</p> <p>-The Operations Manager and the Vice President (VP) of Operations knew about the condition of room #200.</p> <p>-Persons had to "move side by side" to move through room #200.</p> <p>-He was last permitted by the resident to access room #200 in August to clean the filter on the window air conditioning unit.</p> <p>Interview on 11/13/15 at 10:00am with a Housekeeper outside room #200 revealed: -"She [Resident #21] won't let you in." -The resident just asked for paper towels and toilet paper. -"I am covering my drink (placing her hand over her beverage can)" because "I don't want bugs in it."</p> <p>Interview on 11/13/15 at 10:20am with a Housekeeper revealed: -"If there were a fire staff might have to get [Resident residing in room #200] from a window." -The resident residing in room #200 had never allowed her into the room to clean.</p> <p>Interview on 12/13/15 at 12:40pm with the VP of Operations revealed the facility had tried "numerous times" to clean and organize room #200 but the resident would not allow it.</p> <p>Telephone interview on 11/17/15 at 10:35am with the Responsible Person of the resident residing in room #200 was attempted but unsuccessful.</p> <p>Telephone interview on 11/17/15 at 10:45am with</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 19</p> <p>one of the Nurse Practitioner providers of the resident residing in room #200 was attempted but unsuccessful (a message was left and not returned).</p> <p>Telephone interview on 11/17/15 at 10:53am with the RN who performed the licensed health professional support (LHPS) reviews, revealed:</p> <ul style="list-style-type: none"> -She had been assigned to the facility for the previous three months and was still "trying to establish rapport" with the resident residing in room #200. -She referred to the resident residing in room #200 as "the hoarder holed in her room." -The resident was a psychiatric patient who was "secretive" and the RN had limited interactions with the resident. -As the resident had a mental health history, she did not pressure her for anything. -She has had no conversation with staff regarding the resident residing in room #200, but staff were appropriate with the resident. -"These [mental health residents] are my normal clientele" and "you can only fight them on so many things." -A "narrow pathway" was observed in room #200 from the door to the bed and clear to the door. -The facility had probably "tried things historically." -She only reviewed care for residents based on LHPS tasks (review of the most recent LHPS review dated 9/29/15 listed finger stick blood sugars, ACE[wrap]/brace and therapy as her tasks). <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed:</p> <ul style="list-style-type: none"> -The resident residing in room #200 "hoards stuff" and would not let the RCC into her room. -The resident residing in room #200 would tell 	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 20</p> <p>staff if her window blinds were messed up, she was told staff would have to enter her room, which they did, to fix the blinds.</p> <p>-The resident residing in room #200 was told to move stuff from behind her door, but she did not know if it got moved as the resident would not allow staff to enter her room.</p> <p>-The resident residing in room #200 changed her own bed linens, emptied her own trash and "won't let them [facility staff] in to do nothing."</p> <p>-She had told the mental health provider that Resident #21 was a hoarder and that the resident was "a challenge."</p> <p>Telephone interview with the mental health provider for the resident residing in room #200 on 11/18/15 at 12:30pm revealed:</p> <p>-She was aware of the issue with the resident's room being full of clutter and junk, had personally never seen her room and never had heard staff use the word "hoarding."</p> <p>-If someone used the word "hoarding" to her as a therapist it would "set off alarms."</p> <p>-If a Fire Marshall were to inspect the room in uniform and was looking "official," the resident might receive information regarding the clutter in the room and the facility would be empowered to do something about it.</p> <p>-Management of the resident's clutter might include installation of shelving in her closet and on the walls, removing piles of items from behind her door, making sure nothing touched her ceiling and following through with any Fire Marshall recommendations.</p> <p>Review of a Building Walk-through document, provided by the facility and dated 10/29/15 revealed:</p> <p>-Column headings of "room #," "Housekeeping," "Maintenance" and "Comments."</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 21</p> <p>-Resident rooms, resident common areas (bathrooms, dining rooms, day rooms), laundry room and 400 hall end porch were listed under the heading "room #."</p> <p>-After a review of the listed resident rooms, room #200 was not in the column under the heading of "room #."</p> <p>B. Observation on 11/9/15 at 11:40am of room #208 revealed:</p> <p>-A six outlet adapter plugged into a wall outlet alongside the bed.</p> <p>-The outlet adapter did not provide surge protection.</p> <p>-Into the outlet adapter was plugged a television (TV), a digital video disc (DVD) player and a clock radio.</p> <p>-The television and DVD were off and the clock radio was displaying the time.</p> <p>Interview with the resident of room #208 revealed:</p> <p>-The TV and DVD player worked.</p> <p>-No further information was shared regarding the presence of the outlet adapter.</p> <p>Interview on 11/11/15 at 12:15pm with the Maintenance staff member revealed:</p> <p>-Housekeeping staff were expected to give him a list of things "wrong" as he did not personally go into rooms every day.</p> <p>-Housekeeping should check electric outlet covers and switches and report problems to him.</p> <p>-He was "pretty sure" staff knew that surge protectors were the only approved devices if more electric outlets were required.</p> <p>Interview on 11/12/15 at 11:00am with the resident in room #208 revealed:</p> <p>-Her TV and DVD did work.</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 22</p> <p>-Her "boyfriend" had placed the outlet adapter in the wall outlet and he had the same device in his own room (room #404).</p> <p>Observation on 11/12/15 at 11:05am of room #404 revealed the presence of a surge protector plugged into a wall outlet.</p> <p>Interview on 11/12/15 at 3:00pm with a Housekeeper revealed: -He would look for hazards like "broken light switches," "tampered outlets" and broken windows, writing them down and passing them on to the Maintenance staff person. -A hazardous electrical outlet would have "black around it." -The facility had "six prong outlet things" and surge protectors for resident use, but was not sure how long they had them. -He listed resident rooms that he knew had surge protectors.</p> <p>Observation on 11/13/15 at 10:10am of room #105 (accompanied by a Housekeeper) revealed: -A resident sleeping in his bed. -Plugged into the wall outlet behind the chest of drawers between both beds was a 6 outlet adapter, two black plugs to unidentified items plugged into the adapter. -A TV sitting on the chest of drawers was on but the surveyor was unable to determine where it was plugged. -A brown household extension cord with multiple plugs and no surge protection was lying on the chest of drawers next to the TV, and plugged into it was a black plug from an undetermined appliance (the extension cord was not plugged into a wall outlet).</p> <p>Observation on 11/13/15 at 10:15am of room</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 079	<p>Continued From page 23</p> <p>#303 (accompanied by a Housekeeper) revealed: -Two electrical outlets on the wall adjacent to the window. -One of the outlets was flush to the wall with two plugs from undetermined appliances. -The other outlet was a box outlet attached to the wall with electrical supply via conduit, also attached to the wall. -The box outlet had a cracked faceplate (pieces of the faceplate missing) with nothing plugged into it. -Behind the chest of drawers was an outlet with a crack along the top of the faceplate, into which was plugged a compact disc player that was off.</p> <p>Observation on 11/13/15 at 10:20am of room #410 (accompanied by a Housekeeper) revealed: -A six outlet adapter plugged into the wall outlet in the vicinity of the window. -Into the six outlet adapter were plugged a window air conditioning unit (off), a TV (on), a cell telephone charging cord (not plugged into a cell phone), and an oxygen concentrator (off).</p> <p>Interview with a Housekeeper on 11/13/15 at 10:20am revealed no one had trained them on what to look for regarding electrical safety.</p> <p>Interview on 11/13/15 at 1:15pm with the Operations Manager revealed that Maintenance had bought surge protectors.</p> <p>C. Observation of the roaches at various locations throughout the facility between 11/09/15 and 11/18/15 revealed:</p> <p>1. Observation on 11/13/15 at 12:15pm of room #200 revealed: -A sticky insect paper trap that was 3 and ½ inch wide by 6 inch long.</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 24</p> <ul style="list-style-type: none"> -The sticky insect trap paper was on the floor between two heaps of items that were stacked up to 5 feet high off the floor. -The resident had obtained the sticky paper the previous afternoon (11/12/15) from the housekeeper. -The sticky paper was observed to be completely filled with roaches of various sizes. -Most roaches were unable to move due to being stuck on the paper. -There were several roaches that were still moving and wiggling on the paper. <p>Interview on 11/12/15 at 3:00pm and 11/13/15 at 10:20am with the first Housekeeper revealed:</p> <ul style="list-style-type: none"> -He was the "head" of cleaning rooms. - "I have difficulty" keeping room #200 clean, describing it as "very cluttered" and the resident not permitting housekeeping staff to enter the room. -He gave the resident "sticky pads" for "catching insects and rodents," but it had "been a while" since she had "mice" in her room. -Staff were aware of cockroaches in the facility. -When outside pest control technicians came to the facility, staff would tell them "not to water down" the chemical they were spraying. <p>Interview on 11/13/15 at 12:40 pm with the Vice President of Operations revealed:</p> <ul style="list-style-type: none"> -The facility had tried "numerous times" to clean and organize room #200 but the resident would not allow it. -The pest control technician had told the facility "they would never get rid of all the roaches." <p>2. Observations on 11/09/15 at 11:00am of room #411 revealed 2 roaches were observed in bathroom.</p> <ul style="list-style-type: none"> -One roach was on toilet seat and was ½ inch 	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 25</p> <p>long, brown in color.</p> <ul style="list-style-type: none"> -The resident in room #410 at 11:20am said coaches were crawling in his nightstand drawer. -The resident opened the drawers and several roaches were observed crawling in the drawer. -At 11:33am Room 306, several roaches were observed crawling out of the drawer. <p>3. Observation on 11/09/15 at 11:40am in room #208 a roach crawling over the top of the television (TV), and one roach crawling on the chest of drawers under the TV.</p> <p>Interview on 11/09/15 at 11:40am with the resident in room #208 revealed:</p> <ul style="list-style-type: none"> -"Oh, they crawl all over here all the time, you just get used to seeing them." -Somebody comes in and sprays for them all the time. <p>4. Observation on 11/19/15 at 10:12am of a resident in the dining room revealed:</p> <ul style="list-style-type: none"> -Several roaches were crawling on the tables as a resident was sitting eating his snack. <p>Observation on 11/18/15 at 9:20am in the dining room revealed:</p> <ul style="list-style-type: none"> -A square wooden dining room table. -One corner of the wooden table was broken off. -Inside the broken corner was a crack running the length of the broken area. -Two large and one small roach was crawling inside of the broken area. -All three roaches crawled inside the crack and disappeared. -Seven other roaches were observed crawling on the tables and walls next to the tables. -Two roaches were observed to crawl up under a chalk board hanging on the wall next to the tables. 	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 26</p> <p>Observation on 11/18/15 at 12:00pm of the table in the dining room revealed: -The table was still in the dining room and had not been removed. -One roach was crawling inside the broken corner area. -One roach crawling on top of the table. -Another roach crawling on the wall next to the table.</p> <p>Observation on 11/18/15 at 12:10pm revealed: -The table was removed from the dining room and taken outside. -The table was replaced with an unbroken table by housekeeping staff and the Activity Director. -Housekeeping and kitchen staff cleaned all the tables prior to setting the tables for lunch.</p> <p>Review of the facility's Environmental Health Inspection Report of the building dated 10/27/15 revealed: -Many roaches were observed in residents' restroom nesting in baseboard heater. -The facility was advised to contact the pest management company immediately to resolve the issue.</p> <p>Interview on 11/12/15 at 9:00am with Environmental Health Inspectors revealed: -They visited the facility in April 2015 and observed "a lot of roaches." -They received a complaint in October 2015 regarding the roaches, and visited the facility on 10/09/15. -During that visit they observed many roaches. -They told the facility they needed to contact pest control to get the roaches taken care of. -They talked with the maintenance person about "integrative pest management" to get better</p>	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 27</p> <p>control of areas where the pest live, and to control moisture in the building.</p> <p>-A follow-up inspection was done on 10/27/15, he saw a couple of live roaches and a few dead roaches.</p> <p>-With the history of complaints related to roaches, it would be great if the state licensure could impose some type of action on the facility about the roaches that would help them out.</p> <p>Review of the facility's "Building walk through" dated 10/29/15 revealed:</p> <p>-Room #200 was not listed on the report as an existing resident room.</p> <p>-Room #105 was the only room identified as having a problem with roaches.</p> <p>-No roaches were seen in the dining room.</p> <p>-A comment at the end of the report: "There was no roaches seen during the walk through of the building on 10/29/15."</p> <p>Interview on 11/11/15 at 9:50am with the Pest Control company revealed:</p> <p>-He was scheduled to visit the facility monthly.</p> <p>-"When visiting the facility he depended a lot on the housekeeper to show him where the roaches are at."</p> <p>-Over the past year he had changed the chemical treatment used at the facility due the increased population in roaches.</p> <p>-Recently, in the dining room he flipped the tables upside down and sprayed the legs.</p> <p>-Now the heaters are coming on and roaches are coming out through the vents.</p> <p>-"He has been pushing (using) the max chemical allowed by the Federal Drug Administration (FDA) to treat the facility's roaches."</p> <p>-Last month he started mixing two chemicals, one chemical was to make roaches sterile and stop them from reproducing.</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 28</p> <ul style="list-style-type: none"> -He had talked with the facility about residents who hoarded. -There are clutter issues in several rooms. -If the facility called and told him they had an issue he would come more often. -He talked with the housekeeper and the Operations Manager about treatments and recommendations for hoarding and cleaning. -More frequent treatments would be the #1 thing to do. -He does not think the facility will ever get completely rid of the roaches because of the type of building and the age of the building. -He does feel the roaches can be better controlled. -The facility was aware they can call him more frequently, and there was no extra charge for his visit. <p>Interview on 11/11/15 at 10:30am and 12:15pm with the Head Housekeeper revealed:</p> <ul style="list-style-type: none"> -If he knows roaches are more than usual (he sees them every time he enters a room, not opening drawers), he will spray and let the Operations Manager know, then he will call the pest control company to come out. -Also he thought that he had some sticky traps to put down for the roaches, but was unsure, he would search for them. -A man from a pest control company came to the facility once a month to spray. -This pest control technician usually would take a named housekeeper to accompany him through the facility. -Staff would usually say something to Maintenance if pests were a problem. -A named staff person in leadership was reported as saying it was in the pest control company's contract to address issues. -He received no reports from anyone after the 	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 29</p> <p>pest control technician paid a visit.</p> <p>Interview on 11/11/15 at 1:05pm with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -The only way she knew when the roaches had gotten worse was by facility staff or residents informing her. -She thought the roaches had improved since the health inspections report in April 2015, which many roaches were mentioned. -The health inspector returned last month and verbally told her the roaches had improved. -The health inspector said that he saw dead roaches and only a few living roaches. <p>Interviews with 15 residents revealed:</p> <ul style="list-style-type: none"> -One resident said there were roaches all over the facility. -The bug man was here a couple of days ago. -A second resident said he saw roaches daily. -He had not seen "big" roaches in a while, only the small "baby" roaches. -Three residents said roaches always crawled across the tables all time when eating meals. -Two residents in room #306 said there were roaches in their chest and nightstand drawers. Both residents said pest control sprayed monthly, but there were still roaches. -The eighth resident revealed there were roaches in the drawers where food was kept. No staff had informed the residents not to keep food in their room. They had been informed to keep the food closed. No staff checked the room or drawers to ensure food was closed. -A ninth resident in room 401 revealed he had to kill roaches all the time in his room, this morning he killed a roach in his room. -A tenth resident in room 405 revealed "roaches were everywhere," in the drawers, bed and dining room. 	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 30</p> <p>-The eleventh resident revealed the exterminator came to the facility every other month. He observed the exterminator spray along the walls, but there were still roaches. Roaches were in the drawers and night stand.</p> <p>-A twelfth resident revealed roaches sometimes crawled on the bed, especially at night.</p> <p>-The thirteenth resident revealed he regularly saw roaches crawling in the drawer of the night stand. He kept various items in the drawer including his toothpaste. He had also seen roaches in the dining room at various times.</p> <p>-A fourteenth resident revealed there were a lot of roaches "here, the people come in and spray but they are still here, I don't like them."</p> <p>-The fifteenth resident said the pest control company had been to the facility a few days prior to spray for "bugs" which he described as "water bugs."</p> <p>D. Observation on 11/9/15 at 3:35pm of room #105 revealed:</p> <p>-A baseboard heater under the window.</p> <p>-The heater cover was rusted with flakes of paint and rust chipped off.</p> <p>-A 1 ½ inch by 2 foot strip of metal was pulled away from and barely hanging on the heater.</p> <p>-The piece of metal was sticking out from the heater and from under the foot of the bed.</p> <p>Interview on 11/9/15 at 3:35pm with the residents in room #105 revealed:</p> <p>-"It's [the heater cover] been like that for a while."</p> <p>-The housekeeper was aware of it and they told Maintenance a while back.</p> <p>Review of a Building Walk-through document, provided by the facility and dated 10/29/15 revealed no entry for room #105 in the maintenance section of the form.</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 31</p> <p>Review of the most recent Environmental Health Inspectors report dated 10/27/15 revealed a one point deduction for "floors clean, carpet clean, dry, odor free" with the additional comment "walls and ceilings to be in good repair, repair any holes in walls, repair/repaint rusted door frames."</p> <p>Review of an undated comment addendum form to an inspection report, provided by the facility, revealed the following instructions from the health inspector: -"Clean floors throughout- Clean underneath all patient beds- dust/debris buildup present." -"Clean window sills, repaint any rusty areas on door frames, vents, walls, etc."</p> <p>Interview on 11/11/15 at 12:15pm with the Maintenance Supervisor revealed: -He was a "one person shop" but sometimes outside assistance is hired for specialty jobs like tiling. -He was aware of some repairs required on ceilings and walls but his issue was "it's getting time to do stuff." -Housekeeping staff were expected to give him a list of things "wrong"as he did not personally go into rooms every day.</p> <p>Interview on 11/18/15 at 5:15pm with the Assistant Operations Manager revealed: -He supervised Housekeeping staff and was transitioning into being Maintenance Supervisor. -At that time he had not started directly supervising the Maintenance staff on a day to day basis. -There was one Maintenance staff person. -For the past 2 months he assisted the Maintenance staff person on "special projects".</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 079	<p>Continued From page 32</p> <p>Interview with the Operations Manager on 11/19/15 at 9:40am revealed:</p> <ul style="list-style-type: none"> -Maintenance oversight was being transitioned to the Assistant Operations Manager. -At least once per month she went around the building, inside and out and created a list of maintenance and housekeeping issues. -The list was prioritized, distributed to and reviewed with the Maintenance staff and the Assistant Operations Manager who supervised the Housekeeping staff. -The last time the list was done was on 10/29/15. -"Anything safety related" would receive highest priority. -The maintenance issues that occurred on a daily basis were addressed by the Maintenance staff who would have documentation of those issues. -There was one Maintenance person for the building. -There was no formal follow-up process since staff are interacting with one another on a daily basis. -She would review the list when she completed the next walk about the building. <p>_____</p> <p>A Plan of Protection was submitted by the facility on 11/13/15 that included:</p> <p>In reference to pest (roach) problem in rooms specifically 105, 200 & 204</p> <ul style="list-style-type: none"> -The facility staff, mental health provider will work with resident on eliminating clutter and/or hazards from rooms. If residents did not comply with this, facility would have to look at possible discharge of resident/residents due to safety concerns. <p>Attempts to contact guardian of resident in room 204 today to discuss resident's room had been unsuccessful.</p> <ul style="list-style-type: none"> -Facility will continue to contact pest management as often as needed to treat problems areas they are made aware to facility staff. 	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 079	<p>Continued From page 33</p> <p>-Facility staff will remove all coffee pots and microwaves which were potential breeding grounds for roaches.</p> <p>-The UL listed grounded, 6 outlet tap which residents received from family had been removed.</p> <p>_____</p> <p>The violations identified are detrimental to the health, safety and welfare of residents based on the facility's failure to correct multiple hazards, which include excessive clutter in 1 resident room; not using approved surge protection devices to prevent overloading of electrical outlets and having cracked outlet faceplates for 4 resident rooms; not effectively controlling for cockroaches throughout the facility and not repairing a loose metal baseboard heater cover in 1 resident room.</p> <p>DATE OF CORRECTION FOR THE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2016</p>	D 079		
D 087	<p>10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:</p> <p>(1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following:</p> <p>(A) at least one pillow with clean pillow case;</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 087	<p>Continued From page 34</p> <p>(B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and</p> <p>(C) clean bedspread and other clean coverings as needed;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure residents' mattresses were clean, in good condition and had clean sheets as evidenced by dirty and ripped mattresses and no sheets on resident beds.</p> <p>The findings are:</p> <p>Review of a Environmental Health Inspectors sanitation and building report dated 10/27/15 revealed: -Overall score of 93.5. -2 point demerits for mattresses and linens. -Comment; 'Patient contact items must be in good repair, noted some holes in mattresses, linens.'</p> <p>A. Observation on 11/9/15 at 3:30pm of resident room #105 revealed: - A bare green vinyl covered mattress on the bed against the wall with the window. - Numerous strips of dark colored duct tape stretched horizontally across the middle section of the mattress, the longest tape strips approximately 2 feet in length. -The mattress was dirty, dingy and had black marks on it. -There was no sheet on the mattress.</p> <p>Observation on 11/10/15 at 4:05pm of the outside seating area located at the end of the 400 hallway</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 087	<p>Continued From page 35</p> <p>revealed:</p> <ul style="list-style-type: none"> - A bare green vinyl covered mattress, leaning against the building. - The mattress was covered in strips of duct tape and in places had chipping in numerous creases of the vinyl cover. - The concrete directly in contact with the mattress was wet and the rest of the concrete pad was dry. <p>Observation on 11/18/15 at 8:45am of the mattress in room 406 revealed:</p> <ul style="list-style-type: none"> -The mattress on bed #1 by the window had 8 splits of various sizes. -Each split was covered with grey duck-tape. -The resident revealed the mattress had been that way for as long as he had been in the room. -There was talk of getting more mattresses. -The resident was unable to recall any information about getting new mattresses. <p>Confidential interview with a resident in the vicinity of the outside seating area revealed the mattress was not in this area the previous day (11/9/15) when it rained.</p> <p>Interview on 11/10/15 at 4:15pm with a Housekeeper in the 400 hallway revealed:</p> <ul style="list-style-type: none"> - When housekeepers found mattresses in need of replacement it was noted on a sheet and a named staff member in a leadership role had to first confirm it needed replacement. - Mattresses were not permitted to be disposed of in the dumpster and had to be taken to the local landfill. - He was "sure" the mattress was placed outside by a resident and not a staff member. - A mattress was probably taken off an unoccupied bed by a resident to replace this taped mattress, which was placed outside. 	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 087	<p>Continued From page 36</p> <ul style="list-style-type: none"> - The mattress was probably placed outside yesterday as it rained, leaving the concrete wet under it. <p>Interview on 11/11/15 at 12:15pm with the Maintenance Supervisor revealed:</p> <ul style="list-style-type: none"> -He thought the facility recently had purchased 25 to 30 new mattresses. -Staff should have been monitoring mattress condition. -Leadership may have sent some of the new mattresses to a sister facility. -Housekeeping staff were expected to give him a list of things "wrong" as he did not personally go into resident rooms every day. <p>B. Review of a facility "Building Walk Through" comment section dated 10/29/15 revealed:</p> <ul style="list-style-type: none"> -Aides need to make sure pillowcases are clean/not dingy (room #103). -1st bed needs new comforter (room #105). - Pillow case dingy (room #205). -Dingy linen on bed (room #207)'. <p>Observation on 11/9/15 at 3:30pm of resident room #105 revealed:</p> <ul style="list-style-type: none"> - A bare green vinyl covered mattress on the bed against the wall with the window. -The mattress was dirty and dingy with black marks on it. -There was no sheet on the mattress. <p>Observation on 11/9/15 at 3:30pm of resident room #105 revealed:</p> <ul style="list-style-type: none"> -The second resident's bed next to the door had no sheet on the mattress. -There were two large piles of clothes on the bed. -The clothes were pushed towards the wall and with an outline in the clothes where the resident had slept.against them. 	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 087	<p>Continued From page 37</p> <ul style="list-style-type: none"> -A green patterned quilted bedspread, gathered in a pile under a pile of clothes. - That portion of the bedspread sticking out from under the clothes had large sections of fiber fill exposed with pieces of outer fabric missing. <p>Observation throughout the survey 11/9/15 to 11/19/15 of the beds in room #105 revealed no sheets on either mattress.</p> <p>Observation of resident room #101 on 11/9/15 at 3:50pm revealed:</p> <ul style="list-style-type: none"> -There was no sheet on the Residents' bed. -There was a blanket, bedspread and a pillow on the bed. -The pillowcase was dingy and stained. -There was a pile of clothes at the foot of the bed. -The mattress was covered with a clear plastic covering, no sheet. <p>Interview on 11/9/15 at 3:50pm with the resident in room #101 revealed:</p> <ul style="list-style-type: none"> -She usually had a sheet to cover her bed but she missed getting the sheet from staff today. -She would like to have sheet on her bed. -She stated she had slept on the mattress several times with no sheet. <p>Observation and interview on 11/9/15 at 4:15pm of resident room #107 revealed:</p> <ul style="list-style-type: none"> - A yellowed and stained pillow case on the bed by the door. - A yellowed pillow case on the bed by the window. -The sheets and pillowcases always came back dingy and yellow. -He knew they had been washed because they came back folded. <p>Observation and interview on 11/10/15 at 4:03pm</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 087	<p>Continued From page 38</p> <p>of resident room #408 revealed:</p> <ul style="list-style-type: none"> - The bed against the wall with the window with a white sheet with a grey hue. - The pillow case on this bed was observed with small stains. <p>Observation on 11/12/15 at 7:40am in the 400 hallway revealed:</p> <ul style="list-style-type: none"> - The Transportation staff member carrying a stack of folded bed linens. - Visible on the top of the stack of linens was a white pillow case with a yellow tinged hue and a small dime-sized stain. <p>Observation on 11/17/15 at 9:42am of resident room #408 revealed:</p> <ul style="list-style-type: none"> -A resident asleep on a mattress with no sheet. <p>Observation on 11/18/15 at 8:45am of resident room #406 revealed the mattress on bed #1 by the window had 8 rips/tears of various sizes each covered with duct tape.</p> <p>Confidential interview with a resident revealed linens returned to resident rooms smell clean but look yellowed and stained.</p> <p>Interview on 11/18/15 at 1:00pm with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -She was not aware of the mattresses being ripped and taped. -Housekeeping should notify management for replacements. -She was not aware the mattresses did not have sheets on them. <p>Observation on 11/20/15 at 3:50pm of room #105 revealed sheets had been placed on both beds.</p> <p>Interview on 11/20/15 at 3:50pm with one of the</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 087	Continued From page 39 resident's in room #105 revealed: - "I'm in the habit of putting sheets on my bed everyday. - When you happened to see it (the bed) without the sheet, I hadn't put it on yet. - They (the cleaning people) got all over me for it not being done. - They didn't get all over me, but they did say something to me about it (not having sheet on the bed). (He would not elaborate further on this comment.) - I usually put my own sheets on the bed."	D 087		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more 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	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 188	<p>Continued From page 40</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record review, observation and interview, the facility failed to assure staffing met minimal requirements according to census for 5 of 16 night shifts from October 16, 2015 through October 31, 2015 and in addition, the facility failed to meet the needs of the residents identified in the areas of supervision and resident rights.</p> <p>The finding are:</p> <p>Review of the facility's daily census record for October 2015 revealed the facility's in house census between 10/16/15 and 10/31/15 was 69-71 each day.</p> <p>Interview with the Operations Manager (OM) and</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 188	<p>Continued From page 41</p> <p>the Vice President of Operations (VPO) on 11/12/15 at 10:55 am revealed:</p> <ul style="list-style-type: none"> -The Resident Care Coordinator (RCC) was responsible for the staff schedule. -The RCC sends the schedule to the OM for review and approval. -The RCC posts the schedule for staff monthly. -The staff use an electronic time card punch system to record time worked which was processed by an off-site third party vendor. <p>Interview on 11/17/15 at 11:45 am with the RCC revealed:</p> <ul style="list-style-type: none"> -She made the staffing schedule for the Medication Aides (MAs) and personal care aides (PCA). -Staffing schedules were posted every two weeks. -Schedules were posted a "couple of days" before the start date. -For current census (69) she routinely scheduled on first shift two MAs and two PCAs; on second shift, she scheduled two MAs and three PCAs; and on third shift she scheduled one MA and 2 PCAs. -With the current census on third shift she would schedule three PCAs "sometimes" or have someone on second shift work from 11:00 pm to 3:00 am. -She "worked late a lot" and would cover the cart when needed. -When census went above 70 she would add another PCA to the schedule. -She rotated Supervisor duties between the MAs. -The Operations Manager reviewed the schedule before it was posted. -She always emailed a copy of the schedule to the Operations Manager. <p>Interview on 11/17/15 at 11:10 am with the Vice</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 188	<p>Continued From page 42</p> <p>President of Operations and the Operations Manager revealed:</p> <ul style="list-style-type: none"> -The Operations Manager reviewed the staffing schedule before it was posted. -The Operations Manager resided within 500 feet of the facility and was counted towards meeting the third shift supervisor staffing rule. -The Operations Manager reported she was not in the facility for at least 4 hours during third shift nor was she scheduled to be in the facility. <p>Interview with the MA and two PCAs on duty at 11:30 pm on 11/12/15 to 12:30 pm on 11/13/15 revealed:</p> <ul style="list-style-type: none"> -Usually there was the MA and two PCAs. -Sometimes there would be a MA/Supervisor and three PCAs if the census was "up." -The Operations Manager was always available at night by telephone, but rarely came in the building during the shift. -The PCAs are responsible for personal care, supervision, washing, drying and folding laundry, bed changes, cleaned up bathrooms and emptying trash, and sweeping or dust mopping the halls. <p>The MA was the Supervisor of the shift and administered medications and did not routinely perform personal care tasks.</p> <p>Review of the third shift schedule, time cards and daily census for 10/16/15 through 10/31/15 revealed:</p> <ul style="list-style-type: none"> --5 of 16 shifts were staff below the minimum of 24 personal care hours which included 4 hours of Supervision as follows: On Friday, 10/16/15, there were 2 staff for a total of 15.75 hours. On Sunday, 10/18/15, there were 2 staff for a total of 16 hours. On Wednesday, 10/21/15, there were 3 staff for a 	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 188	<p>Continued From page 43</p> <p>total of 23.75 hours. On Saturday, 10/24/15, there were 3 staff for a total of 23.5 hours. On Monday, 10/26/15, there were 3 staff for a total of 23.75 hours. -9 of 16 shifts only met the minimum of 24 personal care hours which included 4 hours of supervision. On Saturday, 10/17/15, there were 3 staff for a total of 24 hours. On Monday, 10/19/15, there were 3 staff for a total of 24 hours. On Tuesday, 10/20/15, there were 3 staff for a total of 24 hours. On Thursday, 10/22/15, there were 3 staff for a total of 24 hours. On Friday, 10/23/15, there were 3 staff for a total of 24 hours On Sunday, 10/25/15, there were 3 staff for a total of 24 hours. On Wednesday, 10/28/15, there were 3 staff for a total of 24 hours. On Thursday, 10/29/15, there were 3 staff for a total of 24 hours. On Friday, 10/30/15, there were 3 staff for a total of 24 hours.</p> <p>Interview on 11/17/15 at 2:50 pm with the Operations Manager revealed: -If a supervisor called and said, "I need more staff and that staff person is willing to come in, then I approve it." -"I never say no to staff coming in when they are short." -One staff is designated as the supervisor on the hall for the shift. -"I'm out there and checking on things as well, especially if residents are having problems." -"I can't recall the last time I brought in extra staff."</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 188	<p>Continued From page 44</p> <p>-"Most incidents/altercations happen on second shift after management staff has left for the day."</p> <p>Another interview with the Operations Manager on 11/18/15 at 9:52 am revealed:</p> <p>-"I struggle more with supervising residents on first shift."</p> <p>-I have asked staff to be on the hall more during each shift.</p> <p>-One staff does need to be in the medication room after a medication pass to answer the phones and do physician orders as they come in.</p> <p>-"We can do rollover on the phones (so the staff in the medication room did not have to answer the telephone) so more staff could be on the hall but we don't."</p> <p>-She reported the Supervisor told her the second shift staff are out on the floor.</p> <p>-She had previously come in on second and third shifts to do random checks and staff have been out on the floor supervising residents.</p> <p>Review of the local county 911 communications log between 10/17/15 and 11/5/15 revealed there were 3 calls during 11:00 pm to 7:00 am which included 2 missing residents and a resident blacked out and fell.</p> <p>Review of the 11/4/15 local county communications full report revealed:</p> <p>-A report of a missing resident called in at 5:02 am by the supervisor.</p> <p>-Under the notes section, the resident was identified as wearing pajamas, no shoes or jacket.</p> <p>-The caller advised "they are short and can't send anyone out to get the [resident]."</p> <p>Based on the non-compliance identified in the areas Resident Rights and Supervision, the</p>	D 188		

Division of Health Service Regulation

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D 188	<p>Continued From page 45</p> <p>facility failed to ensure sufficient was staff on duty to meet the needs of residents.</p> <p>[Refer to Tag 0270, 10A NCAC 13F.0901(b) Supervision] [Refer to Tag 0206, 10A NCAC 13F.0604(e)(1) Personal Care and other Staffing]</p> <p>_____</p> <p>The facility provided the following Plan of Protection on 11/18/15: -"Management will ensure that we have 24 staffing hours, with 4 hours being supervision during the 3rd shift with the 500 foot person being immediately available for the remaining 4 hours." -"In the event that the 500 foot person is not immediately available, management will ensure staffing for 32 hours." -"In addition, management will ensure all schedules are made according to regulation for supervision."</p> <p>_____</p> <p>The violation identified is detrimental to the health and safety of residents as evidenced by the failure of the facility to have sufficient staffing to ensure the safety of the residents as evidenced by the numerous calls to local law enforcement regarding physical assaults, elopements, and the repeated smoking in the facility by residents, as well as not meeting the minimum staffing requirements and assigning direct care staff to laundry responsibilities.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2016.</p>	D 188		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing	D 206		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 206	<p>Continued From page 46</p> <p>10A NCAC 13F .0604 Personal Care And Other Staff</p> <p>The following describes the nature of the aide's duties, including allowances and limitations:</p> <p>(B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation and interview, the facility failed to assure any assigned housekeeping tasks (facility and resident laundry) by aides were limited to occasional, non-routine tasks between 7:00 am and 9:00 pm.</p> <p>The findings are:</p> <p>Review of the facility census on 11/13/15 revealed there were 69 residents currently residing in the facility, with two residents out of the facility.</p> <p>Observations in the laundry room at various times between 11/13/15 and 11/19/15 revealed the following: -On 11/13/15 at 10:00am, there were 2 dryers running, one dryer making a loud noise. The floor was wet with water in front of the right washer and three 30 gallon containers of dirty linen were placed three feet from the washers. One Personal Care Aide (PCA) was in the laundry room doing laundry</p>	D 206		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 206	<p>Continued From page 47</p> <p>-On 11/16/15 at 2:00pm, there were 2 dryers and 2 washers full of clothing/linens and the free standing dryer was making a very loud noise as it operated. There was one staff member in the laundry room folding clothes.</p> <p>-On 11/17/15 at 3:55pm, there were clothes in the stackable dryer and no clothes currently being washed. There were four 30 gallon plastic containers full of soiled laundry three feet away and one large trash bag on the floor full of laundry. There were two staff members in the laundry room folding clothes.</p> <p>Interviews at various times with three first shift Personal Care Aides (PCA) on 11/13/15, 11/16/15 and 11/17/15 revealed:</p> <p>-They are responsible for laundry of facility linens and resident's clothing during their shift every day, in addition to personal care tasks.</p> <p>-Only PCAs are assigned to do laundry.</p> <p>-One aide reported she and the other PCAs completed "22 loads of laundry" on 11/16/15.</p> <p>-The PCAs were responsible for changing bed linens on scheduled resident bath days and washing the removed linens.</p> <p>-The PCAs would also launder residents' personal clothing while doing the facility laundry.</p> <p>-There are a few residents who like to do their own laundry but must wait until the regular laundry was completed.</p> <p>-At the beginning of the shift, the PCAs would fill up the washers and dryers and then go about their other tasks such as snacks, personal care and toileting, showers/baths, linen changes, meal assistance, and supervising smoking.</p> <p>-The PCAs complete all of the personal care tasks and there was usually two or three PCAs each day shift, sometimes four. One PCA was responsible for baths/showers only.</p> <p>-The Medication Aides (MA) did not usually assist</p>	D 206		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 206	<p>Continued From page 48</p> <p>with personal care, but administered medications.</p> <p>Interview with a PCA on 11/13/15 at 10:00am revealed;</p> <ul style="list-style-type: none"> -She had routinely done laundry on her shift for more than a year. -She alternated loads of facility linens with resident clothing until completed or her shift was over. -She did not stay in the laundry room except to fold clothing because the machines make so much noise. -Every PCA on duty is required to help with the laundry. <p>Interview with a housekeeper on 11/13/15 at 11:07am revealed:</p> <ul style="list-style-type: none"> -No housekeeping staff did laundry. -Only PCAs did the laundry. <p>Interview with four second shift PCAs on 11/12/15 between 10:30pm and 11:30pm revealed:</p> <ul style="list-style-type: none"> -All staff helped with facility and resident laundry. -All PCAs assisted residents with toileting, bathing, personal care, linen changes, supervised smoking and assisted with serving snacks and dinner. -All PCAs reported starting laundry when finished making rounds and snacks are served, around 4:00pm. -One PCA worked both 1st and 2nd shift and did laundry on each shift, in addition to all other tasks. <p>Interview with the 3rd shift staff on 11/12/15 between 11:30pm and 11/13/15 at 12:45am revealed:</p> <ul style="list-style-type: none"> -There was usually one MA and two PCAs working each shift. -The MA was responsible for medications and 	D 206		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 206	<p>Continued From page 49</p> <p>supervision.</p> <p>-The two PCAs were responsible for facility and resident personal laundry but there was not as much facility laundry as there was no scheduled bathing and linen changes on 3rd shift.</p> <p>-There were several resident who were up and awake most of the nights and staff tried to "watch them closely."</p> <p>Interview on 11/18/15 at 11:10am with the Vice President of Operations revealed:</p> <p>-First shift staff were doing laundry because there was not extra staff for this task.</p> <p>-No one at the facility had the sole responsibility for doing laundry.</p> <p>-Even though day shift staff did laundry, they still staffed per the census rules; they did not staff extra because staff were doing laundry.</p> <p>[Refer to Tag 0188, 10A NCAC 13F.0604(e)(1) Personal Care and other Staffing]</p> <p>_____</p> <p>The facility provided the following Plan of Protection on 11/18/15: Facility will instruct housekeeping staff to assume this task as part of our Plan of Protection until rule are can be further defined.</p> <p>_____</p> <p>The violation identified is detrimental to the health, safety and welfare of residents as evidenced by the facility's failure to assure sufficient staff for assigned housekeeping tasks (facility and resident laundry) and assigning the housekeeping tasks routinely to aides on all shifts, even when the facility minimally met or was below the minimum staffing requirements.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2016.</p>	D 206		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>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.</p> <p>This Rule is not met as evidenced by: Type A1 Violation</p> <p>Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 of 6 sampled residents as evidenced by one resident, who was deemed incompetent, known by staff to be sexually active and at a higher risk of pregnancy due to antibiotic therapy and resident became pregnant (#26); one resident who was a known smoker and had a known history of starting fires resulting in a fire at the facility (#2) and for various residents with history of repeated smoking in the facility.</p> <p>The findings are:</p> <p>A. Interviews with staff and residents at various times and dates during the survey revealed: -Facility staff do not have a policy and procedure to ensure that residents are competent to make decisions regarding engaging in sexual activity, practicing safe sex and that sexual encounters are consensual. -6 residents were observed by either staff or residents to have sexual encounters in facility (common bathroom or in their rooms). -3 of 6 residents with guardians were engaged in</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 51</p> <p>sexual encounters, not using protection to prevent the transmission of sexually transmitted disease (STDs) or communicable infection.</p> <ul style="list-style-type: none"> -None of the residents had ever known condoms to be available at the facility for residents. -Facility staff, (medication aides and personal care aides) were aware of the residents having sexual encounters because they had observed the sex encounter or the resident had told them of the encounter. -Facility staff revealed the facility had a policy that no residents were allowed to sleep in another resident's bed. -Facility staff also revealed the facility had a policy that no resident was allowed in another resident's room after 10:00pm. -Facility staff had identified residents were sexually active, but did not increased supervision. <p>Review of Resident #26's FL2 dated 08/04/15 revealed:</p> <ul style="list-style-type: none"> -Diagnoses of bipolar disorder, mild mental retardation, and seizures. -The resident needed limited assistance with bathing, and dressing. <p>Review of Resident #26's record revealed the resident was deemed incompetent and had a court appointed guardian. The resident was not allowed to make decisions without the guardian's knowledge.</p> <p>Review of Resident #26's Resident Register revealed the resident was admitted to the facility on 11/05/12.</p> <p>Review of Resident #26's current Care Plan signed by the physician on 11/03/15 revealed:</p> <ul style="list-style-type: none"> -The resident currently received medications for mental illness/behavior. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 52</p> <ul style="list-style-type: none"> -The resident had a history of mental illness. -The resident was receiving mental health services. -The resident required supervision with eating. -The resident was independent all Activities of Daily Living (ADLs). <p>Review of an incident/injury report dated 05/29/15 at 1:00pm revealed:</p> <ul style="list-style-type: none"> -Resident #26 reported to staff that her boyfriend was given \$10.00 by his roommate to have sex with her while he (roommate) was present. -The resident stated she did so willingly because she wanted to please her boyfriend and make him happy. <p>Review of discharge summary report in Resident #26's record revealed:</p> <ul style="list-style-type: none"> -Discharge diagnosis of cervical dysplasia, moderate. -The resident had outpatient survey on 08/10/15 for "cone biopsy." -The instructions on the discharge were "no sexual activity until follow-up or release." <p>Review of Resident #26's record revealed an order dated 9/01/15 for Keflex 500mg three times daily for 10 days for a possible ear infection.</p> <p>Review of Nurse Practitioner orders on 10/13/15 for a pregnancy test for Resident #26 revealed the results were positive, the resident was pregnant.</p> <p>Interview on 11/12/15 at 3:38pm with the housekeeper revealed:</p> <ul style="list-style-type: none"> -He worked for the facility for 18 months. -He had observed Resident #26 was "really the main one going after men." -He had not observed sexual activity with 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 53</p> <p>Resident #26 and other male residents.</p> <ul style="list-style-type: none"> -Resident #26 had been with two residents that were no longer at the facility. -Resident #26 was sometimes in a relationship with Resident #23. -Resident #26 was with one male resident today, then tomorrow with a different male resident. <p>Interview on 11/17/15 at 9:55am with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -She does not know if Resident #26 had been with every man in the building. -She was aware the resident had a boyfriend that his roommate paid to have sex with the resident while the roommate watched. -The incident was reported to the guardian. -No one reported to her that Resident #26 slept with or had sex with every male resident in the building. -The resident's guardian made a comment recently about the resident being in a sexual relationship with "every male resident in the building." -She had heard staff and the physician verbally tell Resident #26 to use a back-up method and condoms. -She had previously offered to take Resident #26 to get condoms, but the resident told her that she was allergic to the latex in the condom. -She did not verify the latex allergy with the resident's physician. -She was unaware if anyone had given or offered Resident #26 condoms. <p>Interview on 11/17/15 at 2:52pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -Regarding resident sexual behavior, staff could not tell them they could not engage in sexual activity. -If residents chose to engage in sexual activity, 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 54</p> <p>their roommate had to know, they had to use protection and do it in privacy.</p> <p>-Residents who engaged in sexual activity were individually taken to the county health department where they could get free condoms.</p> <p>-In the facility, none of the residents had acquired immunodeficiency syndrome, one had herpes and "more" had Hepatitis C (these residents were not sexually active).</p> <p>-Behaviors (mental or sexual) were expected to be documented in progress notes, an incident report completed and also "always" noted in shift reports which were reviewed by the RCC, Operations Manager, and Vice President of Operations.</p> <p>-Shift notes did not get sent to the mental health provider.</p> <p>-Decisions regarding resident discharge were made by the Vice President of Operations and the Operations Manager.</p> <p>-Two residents were mentioned by name who had been recently discharged due to mental aggression behaviors.</p> <p>-If residents were exhibiting mental aggression behaviors then two of the male housekeeping staff would be asked to assist.</p> <p>-Residents showing behaviors were placed on 15 minute checks and documented on a sheet that was signed off by the supervisor at the end of the shift.</p> <p>-The 15 minute check identified the resident's location, what the resident was doing.</p> <p>Review of 15-minute check sheets for Resident #26 revealed:</p> <p>-The resident was on 15 minute checks various days in November and October 2015.</p> <p>-The 15 minute checks showed no evidence Resident #26 was supervised for sexual activity.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 55</p> <p>Observation on 11/09/15 at 4:29pm of Resident #26's room revealed:</p> <ul style="list-style-type: none"> -After knocking on the door several times, then opening the door, Resident #26 was observed in her room, in the bed. -Resident #23 was also in bed with her. -After the door was opened, both residents got out of the bed, and straightened their clothes. -Resident #23 would not leave the room until asked could surveyor privately talk with Resident #26. -Resident #26 assured Resident #23 that he could return after the surveyor had left the room. <p>Interview on 11/09/15 at 4:33pm with Resident #26 revealed:</p> <ul style="list-style-type: none"> -Resident #23 was her boyfriend and was always in her room. -Staff usually knocked on the door and yelled it's time for medications/meals. -Resident #23 stayed in her room all the time. -Some night's staff will tell him to leave, but he comes back. -She and Resident #23 have sexual relations in the room. -When she had a roommate she waited for the roommate to leave the room or go to sleep. -She dated Resident #23 for 3 months and had not been with other men since. -She was pregnant by Resident #23. -Currently, she did not have a roommate, and it was okay for them to be together. <p>Second interview on 11/18/15 at 10:17am with Resident #26 revealed:</p> <ul style="list-style-type: none"> -She previously had been on birth control pills. -She was 11-12 weeks pregnant by her boyfriend who lived at the facility. -She had sex with her boyfriend in her room at the facility. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 56</p> <ul style="list-style-type: none"> -She became pregnant because in August or September 2015 she stopped taking birth control pills. -Two occurrences she had to stop taking birth control; once after a biopsy, and second when she had an ear infection. -The two times were not back to back, but were close in occurrences. -She was aware when not taking the birth control pills she could get pregnant, but she felt pressured by her boyfriend. -The boyfriend continually throughout the day asked her to have sex with him saying, "come on, come on." -Having sex after the biopsy was painful but she did it anyway because the boyfriend kept insisting. -She was verbally told by her guardian and another relative to be careful (not have sex) because she was not taking birth control pills. -No one at the facility had said anything to her about not having sex when she was not taking the birth control pills. -Staff at the facility did not check on her or come into her room during this time. -Staff knocked on the room door to remind about meals/medications, but did not come to her for any other reason. -Her and her boyfriend had sex in the room when she was not on birth control pills in August and September 2015. -A year or more ago one of the medication aides and the Resident Care Coordinator (RCC) previously had tried to get her to use condoms but she was allergic to latex. -When she was not on birth control pills (after her procedure) no one at the facility discussed with her not to have sex, or suggested any other means of protection. -She discovered that she was pregnant when she 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 57</p> <p>began throwing up.</p> <ul style="list-style-type: none"> -She bought a pregnancy test from the dollar store and it was positive. -She showed staff on duty and she was given another pregnancy test ordered by the nurse practitioner. That test results came out positive that she was pregnant. -She was out of the facility over the weekend and returned last night. -Today her boyfriend keeps insisting she have sex with him, but she did not want to have sex because she was bleeding (spots of blood). -She keeps telling him no, but he keeps insisting. -She was uncomfortable so she called a relative to tell about her boyfriend. -She did not have sex yet because she did not want to lose her baby. -She usually was not afraid of her boyfriend, but today she was scared of him. -She had not told staff what was happening today. <p>Interview on 11/17/15 at 10:58am with Resident #26's guardian revealed:</p> <ul style="list-style-type: none"> -Resident #26 had dated almost everyone at the facility. -She was pretty much told by the Operations Manager they can't stop "them," (residents) from doing anything like that. -The facility had never called to inform her they had a concern about Resident #26 being sexually active. -Resident #26 told her, once she had sex with Resident #23 while her roommate was in the room, and the roommate told staff. -There had been times when Resident #26 left the facility and walked up to the church, the facility did not notify her. The resident told her that she left the facility. -Resident #26 even told her that she walked to up 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 58</p> <p>to the Operations Manager's (OM) house. -She was not okay with Resident #26 being pregnant. -One staff (Personal Care Aide, who was also pregnant) told her that Resident #26 being pregnant was "the best thing for the resident." -She told the staff that was not okay. -Resident #26 had been on birth control pills, but had a biopsy done in August 2015. The resident was given antibiotics for seven days, and was unable to take birth control pills. -Shortly afterwards Resident #26 had an ear infection and did another round of antibiotics, meaning she was unable to take her birth control pills. -She verbally told Resident #26 not to have sex. -She "placed 80% of Resident #26 being pregnant on the facility." -Resident #26 was not supervised at all, she needed to be checked on a lot more often. -The facility staff was responsible to supervise Resident #26's activity. -The resident did not make good decisions, which was why she was at the facility, she needed watching.</p> <p>Second interview on 11/18/15 at 4:51 pm with Resident #26's guardian revealed: -On 10/03/15 she had a conversation with the Operations Manager (OM). -During that conversation the OM informed the guardian that Resident #26 was sexually active and had been with almost every guy at the facility. -On that date also the OM informed her that Resident #26's boyfriend was paid \$10.00 by his roommate to watch Resident #26 and the boyfriend engaged in intercourse. -Resident #26 later reported what happened to the OM. -Staff at the facility were responsible to watch</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 59</p> <p>Resident #26. -On 11/14/15 she was at the hospital all day with Resident #26 because the resident was spotting (blood). -The physician at the hospital informed her that was normal for some pregnancies. -Resident #26 needed supervision because the resident does not realize the responsibility of having sex. The resident associates having sex with love. -She had discussed this with the OM, and expected the facility to supervise Resident #26 to prevent sexual relations with other male residents.</p> <p>Interview on 11/12/15 at 10:55pm with the third shift Personal Care Aide (PCA) revealed: -One morning she saw a couple in bed together, it was Residents #23 and #26. -They were in Resident #26's room and the resident had a roommate at the time. -She did not tell the resident to leave the room, and also told the Medication Aide on duty, which was the facility's protocol.</p> <p>Interview on 11/13/15 at 12:10am with the third shift Medication Aide revealed: -Resident #23 was always found in Resident #26's room. -Staff tells him to leave. -He would leave, and they did rounds 2 hours later Resident #23 had returned to Resident #26's room. -No additional monitoring had been done related to the residents being promiscuous. -It was the facility's protocol to check all residents every 2 hours, unless management put the resident on 15 minute checks.</p> <p>Interview on 11/17/15 at 5:10pm with a second</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 60</p> <p>shift Medication Aide revealed:</p> <ul style="list-style-type: none"> -She heard that Resident #26 was promiscuous. -She was unable to recall Resident #26 being put on 15 minute checks for being promiscuous on her shift. -Third shift was much different, she heard they were always finding residents in someone else's room. -The facility did not allow residents in each others rooms after 10:00 pm. -When the Personal Care Aides did their rounds every 2 hours, if they observed a resident in another residents room, they were to ask the resident to leave. -If the residents were observed in sexual activity they were to tell the Medication Aide on duty, because she was the supervisor. -Usually, the residents stopped and got dressed. Residents were told to return to their own room. -The Medication Aide reported to the RCC or the Operations Manager. <p>Interview on 11/30/15 with Resident #26's physician at the women's health care clinic revealed:</p> <ul style="list-style-type: none"> -He did a procedure on Resident #26 on 08/10/15. -The procedure involved the resident's cervix, so it recommended no sexual contact until released by the physician. -A follow-up appointment was scheduled for 08/31/15, during that time the resident should not have been sexually active as stated on the discharge instructions. -If the resident received an antibiotic it would have made the birth control pill less effective. Meaning a person not wanting to get pregnant would have to take extra precaution. <p>Interview on 11/10/15 at 2:58pm with Resident #5</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 61</p> <p>revealed:</p> <ul style="list-style-type: none"> -She was Resident #26's former roommate. -Resident #26 was pregnant, but unsure if the resident (#23) that Resident #23 claimed was the father, was really the father. -Resident #26 told her that she had sex with someone else also. <p>Confidential interview with one of Resident #26's previous roommates revealed:</p> <ul style="list-style-type: none"> -Resident #26 and her current boyfriend were always in the room having sex. -This happened every day. -They did not care that she was in the room or that she could see them. -One time she told the Personal Care Aide on the second shift, and the PCA made them leave the room. -She did not tell staff every time they (Residents #26 and #23) were having sex. -Shortly, after telling staff about Resident #26 and her boyfriend, Resident #26 was moved to another room. -She was not sure why Resident #26 was moved to another room. -Staff did not check the room to monitor and ensure Resident #26 and her boyfriend were not having sex in the room. <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> -He lived at the facility for over 10 years. -Resident #26 had been with various men, (three he could recall), but not him. <p>Attempted interview on 11/19/15 at 12:05pm with Resident #23 revealed, the resident refused an interview.</p> <p>Interview on 11/19/15 at 12:25pm with a Medication Aide revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 62</p> <ul style="list-style-type: none"> -She finds out that residents considered themselves in a relationship when she see the residents holding hands. -She does not see anything happening on first shift (sexual relations). -There was no system to monitor or supervise residents because she does not see a lot of that on the first shift. -Every once in a while there were arguments, but no physical interaction. -If she observed physical interactions, then she follows the chain of command to inform management (Operations Manager and Resident Care Coordinator). -If management tells her then she will put the residents on 15 minute checks. -The 15 minute checks will continue until management tells her to discontinue the checks. <p>Interview on 11/19/15 at 12:35pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -She identified residents were in a relationship, when she saw them hanging out together or they verbally told her they are boyfriend/girlfriend. -Residents have not told they were physically (sexually) active. -There was no way to know if residents are having sex. -If staff find out resident are sexually active, they should call the guardian. -No staff at the facility had come to her and told her they found residents having sex. -Currently, there was no plan in place to protect residents engaged in sexual activity, but one will be put in place. <p>Confidential interviews with 3 residents regarding staff monitoring and supervision revealed:</p> <ul style="list-style-type: none"> -One resident stated staff were usually "shut-up" in the med room. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 63</p> <ul style="list-style-type: none"> -Some staff were out on the floor doing work and laundry. -The Administrator/owner was in the trailer almost daily, "he never comes around and speak to residents." -She stayed in her room all day because she was afraid someone would come into her room and take something. <p>B. Review of the McDowell County Emergency Management Department's fire call report from revealed:</p> <ul style="list-style-type: none"> -19 fire alarm calls from Cedarbrook Residential Center between 5/2/15 to 11/5/15. -15 of the 19 calls were due to smoke sensors being set off (12 in resident rooms and 3 in bathrooms.) -4 calls had no location identified. <p>Review of the facility Smoking Policy (no date) provided by the facility revealed:</p> <ul style="list-style-type: none"> -'If a resident is caught smoking inside the building, immediately all smoking materials are taken from the resident. -The first time a resident is caught smoking inside the building, the resident will be placed on one day cigarette restrictions. Restriction means that the residents can only smoke when a staff member takes the resident outside and supervises the smoking. This will be once every 2 hours. -The second time....will be placed on 3 day restrictions. -The third time.....will be placed on 7 day restriction. -The fourth time....will be placed on fourteen day restriction or as directed by the Administrator and/or Guardian and/or Responsible Person.' - There was no effective date for this policy. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 64</p> <p>Review of a second Smoking Policy provided by the facility dated as revised 12/18/14 revealed:</p> <ul style="list-style-type: none"> -The first time you are caught smoking inside the building, you will not be able to keep any smoking materials for 7 days, you will only be able to smoke with staff supervision. In addition to this you will also be charged a fine of \$3.00 to be deducted from your monthly payout, which will be donated to the local fire department. -The second time you are caught smoking.....not be able to keep any smoking materials for 14 days. In addition....charged a fine of \$6.00 will be deducted from your monthly payout.... -The third time....not be able to keep smoking materials for 30 days.... you will be charged a fine of \$12.00. -Along with the restrictions listed above, you will not be allowed to have a coffee maker or microwave in your room for the duration of your restrictions. These items will be immediately stored in the facility office until your restriction is over. -As well as smoking restrictions and monetary fines, you may also be given a notice to leave facility for smoking in the building.' -A handwritten notation; 'After the third time caught smoking in the building the resident is on indefinite smoking restriction per (Operation Manager's name).' <p>Review of the Environmental Health Inspectors sanitation and building report dated 10/27/15 revealed:</p> <ul style="list-style-type: none"> -Comment section; 'Try to limit smoking to designated outdoor smoking areas. -Evidence of residents smoking in restrooms and other areas. <p>Interview on 11/09/15 at 10:20am with 2 residents on the 400 hall revealed the facility had residents</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 65</p> <p>smoking in the building, (no names given). The residents smoked in the bathrooms and sometimes in the residents' rooms.</p> <p>Interview on 11/09/15 at 11:40am with a third resident on the 400 hall revealed: -He was aware residents sometimes smoked in their bathrooms. -He had been accused of smoking in his bathroom but he did not smoke in building now. -Staff were aware because he told them but there was no way to find out who it was.</p> <p>Interview on 11/9/15 at 11:05pm with a fourth resident revealed: -"Residents smoke in their rooms and set off the fire alarm. -Each time the alarm goes off for smoking it costs \$150. -The fire department charges for the false alarms. -The facility tells us there's no money for outings or activities as a result of having to pay the fire department."</p> <p>Interview on 11/9/15 at 12:15pm with a fifth resident on the 400 hall revealed residents smoked their in rooms.</p> <p>Confidential interview with a resident revealed: -He did not know who smokes in bathroom. -He had to get cigarettes from the med room. -He has not smoked in room or bathroom in the last week.</p> <p>Observation on 11/9/15 at 3:35pm in Room 306 revealed ashes on the bathroom window sill. (1½ inches long) located in the middle of the sill and a faint smell of cigarette smoke.</p> <p>Interview at 3:45pm on 11/9/15 with a resident</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 66</p> <p>revealed:</p> <ul style="list-style-type: none"> -He had seen residents smoking in their rooms. -About every 3 months management brought up smoking in the building. -Some residents were on smoking restrictions, meaning they had their cigarettes given to them by and monitored for smoking. -One resident in a wheelchair had been caught smoking in a room. -He stated the facility should discharge the resident because it was not safe to smoke in the building. <p>Confidential interviews with 4 residents regarding smoking revealed:</p> <ul style="list-style-type: none"> -One resident said there were residents that smoked in their rooms and in the bathrooms. -The fire alarm went off when residents smoked in their rooms that's how staff identified the resident that was smoking. -A second resident revealed the cigarette ashes on the window sill were recently put there, but not by him. -He had seen his roommate smoking in the room, but he also smelled the smoke coming from the bathroom. -A third resident revealed he got caught smoking in the room last week and had not smoked since. -A fourth resident said his roommate smokes in the room all the time. -The medication aide and Personal Care Aide told him to tell his roommate not to smoke in the room. <p>Interview on 11/10/15 at 2:43pm with a resident revealed:</p> <ul style="list-style-type: none"> -Residents smoke in the facility all the time, and even set-off the fire alarm. -When the fire alarm goes off, everyone had to wake-up and go outside. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 67</p> <ul style="list-style-type: none"> -The staff would verbally say "Thanks to _____, (a resident's name) that's why we are out here." -Residents were then put on smoking restrictions and staff was supposed to go out with the resident when they smoked, but they don't go out all the time with the residents on smoking restrictions. -Staff will verbally say "don't come inside." -Sometimes staff would light the resident's cigarette and then staff would come back inside the building. -Resident #25 smoked "weed" in the bathroom. -She was not sure where the resident got the weed. <p>Interview on 11/18/19 at 11:40am with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> -"We do put the residents on smoking restrictions if we find them smoking in the building. -We put them on 15 minute checks for smoking. -We have a smoking log we document on for the 15 minute checks. -We take their cigarettes and lighters away from them. -While on restrictions they can smoke every 2 hours but they have to be supervised by staff. -"The Operations Manager (OM) and the Resident Care Coordinator (RCC) decide when they come off restrictions, especially if they been caught more than once smoking in the building." -Smoking Restriction Log was kept in the staff breakroom. <p>Interview on 11/18/15 at 12:00pm with a Medication Aide revealed (resident's name) was caught smoking last night "and we put it in the book and that is all we can do about it".</p> <p>Interview on 11/18/15 at 12:20pm with a second PCA revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 68</p> <ul style="list-style-type: none"> - She confirmed the same information about the 15 minute checks and logs as the other PCA. -The log sheets are kept in a binder here in the breakroom for us to document in. -Once completed the logs are put up. -I don't know where they are kept or who puts them away. -The OM and RCC says when to put residents on restrictions and when to take them off." <p>Observation on 11/18/15 of the Smoking Restriction Log revealed:</p> <ul style="list-style-type: none"> -Titled entries for resident name, date of offense, offense number, smoking materials, coffee pot/microwave taken, date smoke restriction ends, staff signature and comments. -There were 11 different resident names documented on the log. -The last entry of any offenses was 6/4/15. -Six of the 11 names had multiple offenses documented. -Items documented as taken away from residents for smoking included a microwave, a lighter and cigars. -Smoking restrictions lengths were documented as lasting from 7 days to indefinitely. <p>Observations of the exterior of the facility on 11/13/15 between 10:00am and 10:45am revealed at least 6 resident rooms or bathrooms were missing screens or had broken screens and cigarette butts were on the ground beneath the window area.</p> <p>Interview on 11/18/15 at 11:55am with the Maintenance Supervisor revealed:</p> <ul style="list-style-type: none"> -"The screens missing are on the bathrooms windows where the smokers are. -The screens are also missing if the resident sleeps in the bed next to the window. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 69</p> <ul style="list-style-type: none"> -The screens are either pushed completely out of the windows or bent where the resident throws their cigarettes out the window. -I have found the screens thrown over the bank at the back of the building. -When I walk down the hall I can smell the smoke of residents that are smoking. -If they are caught smoking or misbehave the staff tell the residents they can't have their cigarettes. -In Room 407 and 409 you can smell the cigarette smoke. -Ninety percent of the damages in the building are due to the residents not getting a cigarette. -It's a never ending cycle. The residents tear up or destroy the screens. -I see the residents picking up cigarette butts that other residents or staff throw on the ground so they can smoke them." - He caught residents "all the time" smoking in the building and turned them in so they could be placed on smoking restrictions. -I tell the Medication Aides and they write it in their book." -"That's all I can do." <p>Telephone interview on 11/20/15 at 12:12pm with a local fire department staff revealed:</p> <ul style="list-style-type: none"> - The fire department responded to fire alarms at the facility 3-4 times per month. - "90%" were due to smoking in the facility. -Each month, following the third false fire alarm, the facility is charged \$150. -Staff do a good job with fire alarms, getting the residents evacuated and having a head count when they arrive. -Normally there would be 3 staff at the facility when they arrive. <p>Review of Emergency Management Services July</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 70</p> <p>2015 notices of violations to the facility revealed there were three false fire alarms at the facility during the month. The facility was fined \$150.00.</p> <p>Review of Emergency Management Services August 2015 notices of violations to the facility revealed there were six false fire alarms during the month. The facility was fined \$600.00.</p> <p>Telephone interview on 11/25/15 at 9:59am with the Deputy Director of the local Emergency Management Service (EMS) revealed: -The EMS office has had past issues with the facility due to multiple responses made to the facility. -About 3 to 4 months ago, EMS began fining the facility for false fire alarms. - The facility is charged \$150.00 per false alarm.</p> <p>Interview on 11/30/15 at 11:25am with the Operations Manager revealed: -We try to get Mental Health involved for the smoking behaviors. -The physician progress notes document where they have talked with the resident concerning smoking cessation, but no orders given. -If the behavior continues then will have to look at discharge. -If someone is on restrictions then the staff will go out to supervise them while smoking. -It depends on the resident and if they need full-time supervision or not. -If not the staff will stay for a little while, then come back in and supervise from the building. -She was not aware staff was leaving residents alone when they were on smoking restrictions instead of being there to supervise.</p> <p>Based on the non-compliance identified in the areas of Resident Rights and Supervision, the</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 71</p> <p>facility failed to ensure sufficient staff was on duty to meet the needs of residents related to smoking in the facility.</p> <p>[Refer to Tag 0270, 10A NCAC 13F.0901(b) Supervision] [Refer to Tag 0206, 10A NCAC 13F.0604(e)(1) Personal Care and other Staffing] [Refer to Tag 0338, 10A NCAC 13F.0909 Resident Rights]</p> <p>C. Review of Resident #2's FL2 dated 8/3/15 revealed diagnoses of schizophrenia, hyponatremia and hypocalcemia.</p> <p>Review on 11/10/15 of Resident #2's record revealed: -Date of admission 8/11/15. -Resident came to the facility from a facility that was closing. -Referral for mental health services. -Resident was a smoker. -Date of discharge 10/28/15.</p> <p>Further review of Resident #2's record revealed a notice of discharge form that indicated resident admitted to setting fire to linens in 400 hall bathroom on 10/27/15. Resident discharged on 10/28/15 to local law enforcement.</p> <p>Review of 15 minute check logs for Resident #2 revealed: -A log was started on 10/28/15 at 1:00pm and ended at 3:30pm, discharged. -No other logs were received from the facility for Resident #2.</p> <p>Interview on 11/11/15 at 10:00am with the Resident Care Coordinator (RCC) revealed: -She was working the night of the fire in the 400</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 72</p> <p>hall bathroom.</p> <p>-There were no behavioral concerns with Resident #2, he was "quiet and stayed to himself".</p> <p>-The night of the fire Resident #2 was upset at another resident's behaviors.</p> <p>Interview on 11/11/15 at 3:45pm with second shift medication aide revealed:</p> <p>-She was working the night of the fire.</p> <p>-She worked at the facility where Resident #2 previously resided and remembered his name coming up regarding fires at that facility.</p> <p>-She could not recall if she had informed anyone about Resident #2 concerning this issue.</p> <p>Interview on 11/30/15 at 11:10am with the Operations Manager revealed:</p> <p>-Resident #2 was a smoker.</p> <p>-She was not aware if Resident #2 had any history of setting fires prior to admission.</p> <p>-She became aware of his history following a telephone call with a family member on 10/28/15.</p> <p>-The facility would not admit anyone with a known history of setting fires. She would receive information from all available sources, guardians, social workers, family, other facilities, in order to make an informed decision on admitting a resident.</p> <p>-She had spoken with the facility Resident #2 was transferring from and received no information regarding fire setting behaviors.</p> <p>-She was not aware if Resident #2 had been on smoking restriction at the time of the incident or at any time during his stay at the facility.</p> <p>-She did not know if Resident # 2 was supervised while smoking or had access to a lighter because she did not know if he was on restrictions.</p> <p>-When interviewed by law enforcement, Resident #2 stated he used a lighter to set the fire.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 73</p> <ul style="list-style-type: none"> -The resident could still borrow a lighter from another resident. -When the fire department responded to a fire and they determined the fire to be suspicious, the fire department would contact local law enforcement. -Resident #2 had mental health services but would have to access his record for specifics. -The facility did not have a policy on admissions or discharges and used the rules for adult care homes for admission and discharge guidance. <p>Interview on 11/30/15 at 11:32am with the Vice President for Operations revealed:</p> <ul style="list-style-type: none"> -She had spoken with the administrator at the facility Resident #2 was transferring from prior to accepting him. -The administrator indicated a resident that had already been discharged was responsible for fires at their facility and not Resident #2, "(Resident #2) not one of the prime suspects". -Depending on the circumstances, history and treatment, they would consider admitting a resident with a history of setting fires. The screening process is the same for any prospective admission. -The facility did not have a policy for admissions and discharges and used the rules for adult care homes for admission and discharge guidance. -On 10/28/15 she viewed the camera footage of the 10/27/15 incident and called the emergency medical services director due to Resident #2 being in the area of the fire and because Resident #2 had been very verbal about specifics of the fire, "he seemed to know too much" about what had happened. -Per the fire department report of the 10/27/15 incident, they (the fire department) had contacted the fire investigator. -Resident #2 had mental health services but 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 270	<p>Continued From page 74</p> <p>would have to access his record for specifics.</p> <p>Telephone interview on 11/25/2015 at 12:31pm with a detective from the McDowell County Sheriff's Office revealed:</p> <ul style="list-style-type: none"> -Resident #2 intentionally set a fire in the facility on 10/27/2015 and the fire department responded. -The facility did not contact law enforcement until 10/28/2015. -Law enforcement arrested Resident #2 on 10/28/2015. -The facility was aware that Resident #2 had been suspected of setting fires in the facility where he previously lived. -Police interview notes revealed that the facility's Vice President of Operations told law enforcement on 10/28/2015 that the facility was advised by Resident #2's former facility that they had dealt with Resident #2 and fires at their facility. -The detective considers Resident #2 to be very dangerous. <p>Review of the local fire department's report dated 10/28/15 revealed:</p> <ul style="list-style-type: none"> -They received and responded to a fire alarm from the facility on 10/27/15 at 10:15pm. -Upon arrival at the facility staff had reported the fire had been extinguished and was located in the bathroom on 400 hall. -The staff reported all residents were accounted for and had been evacuated from the building. -Cause of ignition was intentional. -Fire department personnel did not have a suspect and the scene was turned over to the local county law enforcement office and emergency medicine service for further investigation into the arson case. -Fire department personnel were on-site from 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	<p>Continued From page 75</p> <p>10:20pm to 11:03pm.</p> <p>Telephone interview on 11/25/15 at 9:59am with the Deputy Director of the local Emergency Management Service revealed:</p> <ul style="list-style-type: none"> -He conducted the fire investigations in the county and had conducted the investigation at the facility. -The facility called him on 10/28/15 because they had reviewed their camera recording and noticed residents in the vicinity of the 400 hall bathroom around the time of the fire. -Through conversation (Resident #2) admitted to setting fires when he became upset or agitated. -During the investigation he spoke with a neighboring county fire investigator and learned that (Resident#2) was a person of interest for them with setting fires in their county. -He was "glad" the facility discharged Resident #2. <p>_____</p> <p>A plan of protection was submitted by the facility on 11/18/15 that included:</p> <ul style="list-style-type: none"> -Management will notify primary care of residents known to be sexually active so that additional education can also be provided. -Management will contact guardians of residents who are known to be sexually active to discuss any concerns. -Facility staff will provide increased supervision to residents on smoking restriction. -Staff will immediately report evidence of smoking inside the facility and continue to enforce (the) smoking policy. -Management will contact (the) communicable disease nurse with the local health department to assist with education for residents who have a recent diagnosis of (a) communicable disease. -Specific named residents will be placed on increased supervision until education is provided from the health department. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 270	Continued From page 76 -Management will speak to guardians for further direction. The violations identified resulted in serious neglect as evidenced by the failure of the facility to provide supervision or monitoring for Resident # 26, who was deemed incompetent and known to be sexually active, during a time period the resident was not to be sexually active and became pregnant; and, the failure to provide adequate supervision or monitoring of residents who smoked in the facility and for Resident #2, with a known history of starting fires and started a fire in the facility, placing the safety of all residents at risk. DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2015.	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 observation, record review and interviews, the facility failed to assure referral and/or physician notification for 1 of 1 sampled resident who was deemed incompetent, known by staff to be sexually active, and at a higher risk of pregnancy due to antibiotic therapy, and the resident became pregnant (#26); 1 of 1 sampled	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 77</p> <p>resident with unabated hoarding (#21); 1 of 6 sampled residents regarding refusing blood pressure checks and fingerstick blood sugar checks (#17); and, 1 of 6 sampled residents refusing medications (#22).</p> <p>The findings are:</p> <p>A. Review of Resident #26's FL2 dated 08/04/15 revealed: -Diagnoses of bipolar disorder, mild mental retardation, and seizures. -The resident needed limited assistance with bathing and dressing.</p> <p>Review of Resident #26's record revealed the resident was deemed incompetent and had a court appointed guardian. The resident was not allowed to make decisions without the guardian's knowledge.</p> <p>Review of Resident #26's Resident Register revealed the resident was admitted to the facility on 11/05/12.</p> <p>Review of Resident #26's current Care Plan signed by the physician on 11/03/15 revealed: -The resident currently received medications for mental illness/behavior. -The resident had a history of mental illness. -The resident was receiving mental health services. -The resident required supervision with eating. -The resident was independent all Activities of Daily Living (ADLs).</p> <p>Review of a discharge summary report in Resident #26's record revealed: -Discharge diagnosis of cervical dysplasia, moderate.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 78</p> <p>-The resident had outpatient survey on 08/10/15 for "cone biopsy."</p> <p>-The instructions on the discharge were "no sexual activity until follow-up or release."</p> <p>Review of Resident #26's record revealed an order dated 9/01/15 for Keflex 500mg three times daily for 10 days for a possible ear infection.</p> <p>Review of Nurse Practitioner orders on 10/13/15 for a pregnancy test for Resident #26 revealed the results were positive, the resident was pregnant.</p> <p>Interview on 11/30/15 with Resident #26's physician at the women's health care clinic revealed:</p> <p>-He did a procedure on Resident #26 on 08/10/15.</p> <p>-The procedure involved the resident's cervix, so it was recommended no sexual contact until released by the physician.</p> <p>-A follow-up appointment was scheduled for 08/31/15, during that time the resident should not have been sexually active.</p> <p>-His records does not show the resident was given an antibiotic.</p> <p>-However, if the resident was given an antibiotic, she could have still continued to take her birth control pill.</p> <p>-The antibiotic will make the birth control pill less effective. Meaning a person not wanting to get pregnant would have to take extra precaution.</p> <p>-No one from the facility had called to inform them the resident was sexually active after her procedure.</p> <p>-No one from the facility had called to ask about other means of protecting Resident #26 while on an antibiotic.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 79</p> <p>Interview on 11/17/15 at 9:55am with the Operations Manager revealed: -She was aware Resident #26 had a procedure a few months back. -She was unaware Resident #26 was not taking birth control pill.</p> <p>Interview on 11/09/15 and 11/18/15 at 4:33pm and 10:17am with Resident #26 revealed: -Resident #23 was her boyfriend and was always in her room. -She dated Resident #23 for 3 months and had not been with other men since. -She was pregnant by Resident #23. -She previously had been on birth control pills. -She was 11-12 weeks pregnant by her boyfriend who lived at the facility. -She became pregnant because in August or September 2015 she "stopped taking birth control pills because she was on an antibiotic." -She had two occurrences when she stopped taking birth control; once after a biopsy, and second when she had an ear infection. -The two times were not back to back but were close in occurrences. -She was aware when not taking the birth control pills she could get pregnant, but she felt pressured by her boyfriend. -Having sex after the biopsy was painful but she did it anyway because the boyfriend kept insisting. -She was verbally told by her guardian and another relative to be careful (not have sex) because she was not taking birth control pills. -No one at the facility had said anything to her about not having sex when she was not taking the birth control pills. -When she was not on birth control pill (after her procedure) no one at the facility discussed with her not to have sex, or suggested any other</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 80</p> <p>means of protection.</p> <p>Interview on 11/17/15 at 10:58am and 11/18/15 at 4:51pm with Resident #26's guardian revealed:</p> <ul style="list-style-type: none"> -The facility had never called to inform they had a concern about Resident #26 being sexually active. -She was not okay with Resident #26 being pregnant. -Resident #26 had been on birth control pills, but had a biopsy done in August 2015. The resident was given antibiotics for seven days, and was unable to take birth control pills. -Shortly afterwards Resident #26 had an ear infection and did another round of antibiotics, meaning she was unable to take her birth control pills. -The resident did not make good decisions, which was why she was at the facility, she needed watching. -On 10/03/15 she had a conversation with the Operations Manager (OM). -During that conversation the OM informed the guardian that Resident #26 was sexually active and had been with almost every guy at the facility. -No conversations about Resident #26's sexual activity prior to 10/03/15. <p>B. Review of Resident #21's most current FL-2 dated 8/10/15 revealed diagnoses which included schizophrenia, bipolar disorder, mental retardation and depression with anxiety.</p> <p>Review of Resident #21's assessment and care plan dated 5/12/15 and signed by the Resident Care Coordinator (RCC) and nurse practitioner provider revealed:</p> <ul style="list-style-type: none"> -"Resident continues to do well" and "when upset she is easily directed." -History of mental illness was checked and she 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 81</p> <p>was receiving mental health services.</p> <p>-The care plan listed in the section for Licensed Health Professional Support (LHPS) and "other special care needs" pre-printed options which included "housekeeping" that was given a performance code of 4 (totally dependent).</p> <p>-There was no further documentation specific to housekeeping needs for this resident.</p> <p>Review of LHPS notes for Resident #21 revealed:</p> <p>-No documentation of housekeeping concerns for notes dated 12/2/14, 3/2/15, 6/3/15 and 9/29/15.</p> <p>-The notes of 9/29/15 listed finger stick blood sugars, ACE[wrap]/brace and therapy as her tasks.</p> <p>-The note dated 9/29/15 documented that the "resident was observed in her bed."</p> <p>Review of a primary care provider notes for Resident #21 dated 3/31/15 revealed:</p> <p>-"She does not keep room clean. Staff reports unable to walk through room. Staff states will not get up to take medications often."</p> <p>-Under the heading of activities of daily living (ADL) was circled the statement "needs assistance."</p> <p>-Under the heading of psych[iatric], the resident was documented as alert and oriented x3 (person, place and time) and "viewed room-unable to get in due to all her belongings."</p> <p>-The diagnosis of "hoarder."</p> <p>-Documentation that the resident refused medications for 8 days in the month of March and "recommend psych[iatric] eval[uation]."</p> <p>Review of a mental health provider note for Resident #21 dated 4/23/15 revealed:</p> <p>-A chief complaint of "anxiety and depressed mood continue to interfere w[with]/pt [patient] functioning."</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 82</p> <p>-Session content which included that due to the "pt hoarding" and multiple incidents of refusal to take medications as prescribed, the MD [physician] did not think the resident to be competent.</p> <p>-Session content with the resident reporting that "I clean my room every day."</p> <p>Review of a mental health provider note for Resident #21 dated 5/14/15 revealed: -A chief complaint of "anxiety and depressed mood continue to interfere w [with]/pt [patient] functioning."</p> <p>-Session content included the resident was "out of sorts" and "not open to considering alternative perspectives or any considerations that did not agree w [with]/ her current assertions."</p> <p>-Session content included that the resident "left session without practicing healthy coping skills and apparently not happy w [with]/ this therapist."</p> <p>Review of a staff progress note on Resident #21 dated 10/6/15 revealed: -The resident had "several refusals" of her morning (AM) medications. -She would not get up and would not allow staff into her room. -The MD (physician) and mental health would be notified.</p> <p>Review of the most recent notes from an Adult Nurse Practitioner (ANP) associated with the mental health provider for Resident #21 dated 10/13/15 revealed: -"Pt [patient] with chronic paranoid schizophrenia with mood lability and anxiety," "mild paranoia but overall she appears to be well-managed at this time" and "no changes in medications or therapies suggested." -For justification of the antipsychotic medication</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 83</p> <p>quetiapine the resident was noted having "chronic paranoid delusions" and gradual dose reduction (GDR) was contraindicated.</p> <p>Review of a Building Walk-through document, provided by the facility and dated 10/29/15 revealed after a review of the listed resident rooms, the room occupied by Resident #21 was not in the column under the heading of "room #."</p> <p>Observation on 11/12/15 at 2:15pm of Resident #21's room revealed:</p> <ul style="list-style-type: none"> -A stack of items approximately 3 feet high and 1 foot deep to the wall were noted immediately inside and to the right of the door frame. -A stack of items approximately 5 feet high were observed immediately to the left of the door frame, including a college dormitory-sized white refrigerator and box fan, which prevented the door from swinging all the way open. -A path, which exposed floor and measured from 1 to 2 feet wide, went from the door frame to a large green plastic container measuring approximately 2 feet wide by 3 feet long, the plastic container placed parallel to the bed (located against the wall where the window was located). -The large green plastic container prevented direct and clear egress from the bed to the door, with a path circumscribing the plastic container approximately 1 foot wide. -Piles of clothes, plastic bags and stuffed animals lined the paths in the room. -A path, which exposed floor and measured from 1 to 2 feet wide, turned right inside the door and went to the bathroom, with piles of items on either side of the path. -The door to the bathroom was open, space surrounding the commode in the bathroom was taken by various items stacked approximately 5 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 273	<p>Continued From page 84</p> <p>to 6 feet up the walls.</p> <p>-Clothing was hanging across the top of the bathroom door.</p> <p>-A bureau approximately 5 to 6 feet long was pushed against a partially closed bi-fold closet door, with clothes pushing out of the drawers and with items (including a microwave) stacked on top of the bureau to the approximately 5 foot mark on the wall.</p> <p>Interview of Resident #21 on 11/12/15 at 2:15pm (inside her room) revealed the closet was "full of stuff."</p> <p>Interview on 11/12/15 at 3:00pm with a Housekeeper revealed:</p> <p>-He was the "head" of cleaning rooms.</p> <p>-He would first "troubleshoot" rooms occupied by residents known to be "messy" or for those known to experience urine incontinence in bed, then proceed to cleaning other rooms.</p> <p>-He included the room of Resident #21 in a group of those residents occupying single, private rooms, which were "checked daily."</p> <p>-"I have difficulty" keeping Resident #21's room clean, describing it as "very cluttered" and the resident as not permitting housekeeping staff to enter the room.</p> <p>-Resident #21 "had lots of stuff."</p> <p>-Resident #21 would ask Housekeeping staff for paper towels, toilet tissue and "sticky pads" for "catching insects and rodents," but it had "been a while" since she had "mice" in her room.</p> <p>-The Operations Manager and Vice President (VP) of Operations knew about the condition of Resident #21's room.</p> <p>-Persons had to "move side by side" to move through Resident #21's room.</p> <p>-He was last permitted by the resident to access Resident #21's room in August to clean the filter</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 85</p> <p>on the window air conditioning unit.</p> <p>Interview on 11/13/15 at 10:00am with a Housekeeper outside Resident #21's room revealed:</p> <ul style="list-style-type: none"> - "She [Resident #21] won't let you in." - The resident just asked for paper towels and toilet paper. - "I am covering my drink (placing her hand over her beverage can)" because "I don't want bugs in it." <p>Interview on 11/13/15 at 10:20am with a Housekeeper revealed:</p> <ul style="list-style-type: none"> - "If there were a fire staff might have to get [Resident #21] from a window." - Resident #21 had never allowed her into the room to clean. <p>In addition to the observations made on 11/12/15, further observation of Resident # 21's room on 11/13/15 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - A path, which exposed floor and measured approximately from 1 to 2 feet wide, turned right inside the door and went to the bathroom, with piles of items on either side of the path. - The door to the bathroom was open, space surrounding the commode in the bathroom (visible from just inside the door frame of the room) was taken by various items stacked approximately 5 feet up the walls. - Numerous items were stacked on the vanity next to the sink, including dishes and a dish rack. - A bureau approximately 5 to 6 feet long was pushed against a partially closed bi-fold closet door, with clothing pushing out of the drawers and with items (including a microwave) stacked on top of the bureau to the approximately 5 foot mark on the wall. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 86</p> <p>Interview on 12/13/15 at 12:40pm with the VP of Operations revealed the facility had tried "numerous times" to clean and organize Resident #21's room but the resident would not allow it.</p> <p>Telephone interview on 11/17/15 at 10:35am with Resident #21's Responsible Person was attempted but unsuccessful.</p> <p>Telephone interview on 11/17/15 at 10:45am with a Nurse Practitioner from Resident #21's primary care clinic was attempted but unsuccessful.</p> <p>Telephone interview on 11/17/15 at 10:45am with an administrative office employee of the mental health provider for Resident #21 revealed: -The resident was last seen by the mental health provider on 5/14/15 and was no longer receiving services. -The resident was seen on 8/18/15, 9/16/15 and 10/13/15 by the nurse practitioner providing review of the resident's psychiatric medication management.</p> <p>Telephone interview on 11/17/15 at 10:53am with the RN, who performs the licensed health professional support (LHPS) reviews, revealed: -She had been assigned to the facility for the previous three months and was still "trying to establish rapport" with the resident residing in room #200. -She referred to the resident residing in room #200 as "the hoarder holed in her room." -The resident was a psychiatric patient who was "secretive" and the RN had limited interactions with the resident. -As the resident had a mental health history, the RN did not pressure her for anything. -She has had no conversation with staff regarding the resident residing in room #200, but staff were</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 87</p> <p>appropriate with the resident.</p> <p>-"These [mental health residents] are my normal clientele" and "you can only fight them on so many things."</p> <p>-A "narrow pathway" was observed in room #200 from the door to the bed and clear to the door.</p> <p>-The facility had probably "tried things historically."</p> <p>-Regarding the resident's room, "if it has gotten to the point with cockroaches then it needs to be addressed."</p> <p>-She only reviewed care for residents based on LHPS tasks .</p> <p>Interview with the Nurse Practitioner (NP), associated with the mental health provider for Resident #21. on 11/17/15 at 2:13pm revealed:</p> <p>-He was an Adult NP who was "working on" his psychiatric mental health NP credentials.</p> <p>-He was providing medication review services only and another provider performed counselling services for residents.</p> <p>-Referral for services were requested by a Power of Attorney (POA) or guardian for a resident with the Resident Care Coordinator (RCC) or the VP of Operations after obtaining POA/guardian consent.</p> <p>-If residents exhibited behaviors staff would call the mental health provider and if stable, staff would tell them in person when they came to the facility.</p> <p>-He came to the facility each week.</p> <p>-Reviews of psychiatric medications were at least monthly but could be every two weeks if necessary.</p> <p>-He expected staff to call the mental health provider triage line if things changed for residents.</p> <p>-The mental health provider created no specific mental health care plans for their assigned</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 88</p> <p>residents. "Real bad" residents were seen by another named mental health provider and he saw "stable" residents.</p> <p>-Resident #21 did "very well" and was one of the higher functioning residents at the facility.</p> <p>-Resident #21 exhibited some "paranoia," had focused the last previous months on perceived wrongs and was a bit suggestable.</p> <p>-Resident #21 "has hoarding qualities," liked to be in control and got "very touchy" if anyone tried to touch her stuff.</p> <p>-Staff had shown "concern" with hoarding tendencies.</p> <p>-A few weeks prior, an exterminator was in the facility spraying and he did not go into Resident #21's room.</p> <p>-Resident #21's hoarding tendencies had been going on for "many, many years," "medicine will not fix" the tendencies and you have to "try to work around it."</p> <p>-"Hoarding is detrimental when someone is so afraid someone will clean their room they will not leave their room."</p> <p>-He would also defer to the health care provider as there might be some health concerns, "like food" is in the room.</p> <p>-There used to be a facility requirement that residents could "only have so much" in possessions.</p> <p>-"I think the facility needs to address the hoarding issue."</p> <p>-He had never seen her room, as he interviewed residents in a separate room.</p> <p>-He reviewed every note with the licensed therapist in the mental health practice.</p> <p>-"I would want to know from staff if [resident's] hoarding resulted in [pest] infestation."</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 89</p> <ul style="list-style-type: none"> -Resident #21 "hoards stuff" and would not let the RCC into her room. -Resident #21 would tell staff if her window blinds were messed up, she was told staff would have to enter her room, which they did, to fix the blinds. -The resident was told to move stuff from behind her door, but she did not know if it got moved as the resident would not allow staff to enter her room. -The resident changed her own bed linens, emptied her own trash and "won't let them [facility staff] in to do nothing." -Staff did not tell her that Resident #21 had cockroaches and that the pest control technician had "attempted" to spray for them, but she was not sure if the technician got into the resident's room. -Resident #21 refused to talk to the mental health provider and she was not sure why. -She had told the mental health provider that Resident #21 was a hoarder and that the resident was "a challenge." <p>Telephone interview with the mental health provider for Resident #21 on 11/18/15 at 12:30pm revealed:</p> <ul style="list-style-type: none"> -Counseling per se is something the resident is unable to effectively use. -The resident was not "moving forward" with meeting her goals, was "not dealing with reality," got angry with the therapist and refused to see her. -The resident had no insight, had cognitive limitations and it was difficult for her to receive input. -She was aware of the issue with the resident's room being full of clutter and junk, had personally never seen her room and never had heard staff use the word "hoarding." -If someone used the word "hoarding" to her as a 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 90</p> <p>therapist it would "set off alarms." -Hoarding is more "self-abuse" and "self-neglect." -With the resources the facility had they were doing "the best they could." -Due to the resident's lack of insight and hostility, the facility did not think it worthwhile to send the resident to the hospital, which is what should probably happen. -If a Fire Marshall were to inspect the room in uniform and looking "official," she might receive information regarding the clutter in the room and the facility would be empowered to do something about it. -Management of the resident's clutter might include installation of shelving in her closet and on the walls, removing piles of items from behind her door, making sure nothing touches her ceiling and following through with any Fire Marshall recommendations. -It was emotionally distressing for a hoarder to have other people touch their stuff.</p> <p>C. Review of Resident #22's current FL-2 dated 08/20/15 revealed diagnoses included schizoaffective disorder, hypertension and diabetes mellitus.</p> <p>1. Review of Resident #22's record revealed medications ordered on the FL-2 dated 8/20/15 and signed physician orders dated 9/30/15 included an order for Advair 115/21 inhaler (a combination of steroid/bronchial dilator inhaler used to treat asthma or chronic obstructive pulmonary disease) 2 puffs twice a day.</p> <p>Observation of medication administration on 11/10/15 at 8:13am revealed Resident #22 refused administration of Advair 115/21 inhaler.</p> <p>Interview on 11/10/15 at 8:13am with Resident</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 91</p> <p>#22 revealed he refused the inhaler because he did not need the inhaler.</p> <p>Review of Resident #22's electronic Medication Administration Record (eMAR) for September 2015, October 2015, and November 2015 revealed:</p> <ul style="list-style-type: none"> - Advair 115/21 inhaler 2 puffs twice a day was scheduled for administration at 8:00am and 8:00pm daily. -Advair was documented as refused 12 of 21 opportunities at 8:00pm in September 2015 (9/1, 9/12, 9/13, 9/14, 9/16, 9/18, 9/20, 9/23-25, 9/28 and 9/30) and 2 of 21 opportunities at 8:00am (9/19 and 9/20). -Advair was documented as refused 22 times with 31 opportunities at 8:00pm in October 2015 (10/1-4, 10/6-8, 10/10-12, 10/14, 10/16, 10/18-20, 10/22, 10/24-26, and 10/28-30) and 4 times with 31 opportunities at 8:00am (10/4, 10/7, 10/12, and 10/17). -Advair was documented as refused in November 2015 (from 10/1/15 to 10/9/15) 8 of 10 opportunities at 8:00pm (11/1-4, 11/6-9), and one of 10 opportunities at 8:00am on 10/10/15. <p>Review of Resident #22's record revealed no documentation for physician notification for the resident refusing Advair 115/21 inhaler.</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed "FYIs [for your information]" were sent to providers especially if medications were refused three days in a row.</p> <p>Refer to interview on 11/12/15 at 10:38am with a Medication Aide (MA).</p> <p>Refer to interview on 11/13/15 at 1:50pm with two</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 92</p> <p>dayshift MAs.</p> <p>Refer to interview on 11/13/15 at 2:40pm with a second shift MA.</p> <p>Refer to interview on 11/17/15 at 2:50pm with the Operations Manager.</p> <p>Refer to interviews on 11/18/15 at 9:35am and 3:00pm with the RCC.</p> <p>Refer to interview on 11/18/15 at 2:25pm with the facility's Primary Care Physician's Assistant.</p> <p>2. Review of Resident #22's record revealed: -Signed physician orders from a physician visit dated 10/5/2015 ordering an antibiotic and Symbicort (a combination steroid and short acting bronchial dilator used to treat chronic obstructive pulmonary disease) 160/4.5 inhaler 2 puffs twice a day for 30 days. -A subsequent physician order dated 10/6/15 to change to QVAR (a steroid inhaler) 40 mcg oral inhaler due to insurance coverage.</p> <p>Observation of medication administration on 11/10/15 at 8:13am revealed Resident #22 refused administration of QVAR 40 mcg inhaler.</p> <p>Interview on 11/10/15 at 8:13 am with Resident #22 revealed he refused the inhaler because he did not need the inhaler.</p> <p>Review of Resident #22's eMARs for October 2015, and November 2015 revealed: -QVAR 40 mcg inhaler was listed from 10/7/15 to 11/30/15 on the eMARs and scheduled for administration at 8:00am and 8:00pm daily. -QVAR was documented on the resident's eMAR as refused 17 of 25 opportunities at 8:00pm and</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 93</p> <p>3 of 25 opportunities at 8:00am from 10/07/15 to 10/31/15.</p> <p>-QVAR was documented on the resident's eMAR as refused 8 of 9 opportunities at 8:00pm, from 11/1/15 to 11/09, and 1 of 10 opportunities at 8:00am from 11/1/15 to 11/10/15.</p> <p>Review of Resident #22's record revealed no documentation for physician notification for the resident refusing QVAR 40 mcg inhaler 30 times from 10/7/15 to 11/10/15.</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed "FYIs [for your information]" were sent to providers especially if medications were refused three days in a row.</p> <p>Refer to interview on 11/12/15 at 10:38am with a Medication Aide (MA).</p> <p>Refer to interview on 11/13/15 at 1:50pm with two dayshift MAs.</p> <p>Refer to interview on 11/13/15 at 2:40pm with a second shift MA.</p> <p>Refer to interview on 11/17/15 at 2:50pm with the Operations Manager.</p> <p>Refer to interviews on 11/18/15 at 9:35am and 3:00pm with the RCC.</p> <p>Refer to interview on 11/18/15 at 2:25pm with the facility's Primary Care Physician's Assistant.</p> <p>C. Review of Resident #17's current FL-2 dated 12/2/14 revealed diagnoses included schizoaffective disorder, hypertension thyroid disease, and diabetes.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 94</p> <p>Review of Resident #17's record revealed: -An order dated 12/1/14 to check blood pressure 2 times a week (Sunday and Thursday). -An order dated 12/1/14 to check fingerstick blood sugar (FSBS) 2 times a day on 3 days each week and a subsequent physician's order dated 2/3/15 to check FSBS 2 times a day one time a week. -Signed physician's orders dated 9/30/15 for check blood pressure 2 times a week (Sunday and Thursday), and to check FSBS 2 times a day on Mondays.</p> <p>Review of Resident #17's electronic Medication Administration Record (eMARs) for September 2015, October 2015, and November 2015 revealed: -FSBS checks were scheduled on Mondays at 7:30am and 5:30pm. -FSBS values were documented as refused at 7:30am and 5:30pm on 9/7/15, 9/14/15, and 9/21/15. (September 2015 documented FSBS range was 105-149.) -FSBS values were documented as refused at 5:30pm on 10/5/15, and at 7:30am on 10/19/15. (October 2015 documented FSBS range was 100-133.) -FSBS values were documented as refused at 7:30am on 11/2/15 and 11/9/15. (November 2015 documented FSBS range was 116-134.)</p> <p>Review of Resident #17's eMARs for September 2015, October 2015, and November 2015 revealed: -Blood pressure checks were documented as refused on 9/6/15, 9/10/15, 9/17/15, 9/20/15, and 9/24/15. (Documented blood pressures were 111/82 on 9/3/15, 122/70 on 9/13/15, and 111/77 on 9/27/15.)</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 95</p> <p>-Blood pressure checks were documented as refused on 10/4/15, 10/8/15, 10/11/15, 10/15/15, 10/18/15, 10/22/15, 10/25/15, and 10/29/15. (Documented blood pressure was 118/72 on 10/01/15).</p> <p>-Blood pressure checks were documented as refused on 11/8/15. (Documented blood pressures were 118/78 and 112/70.)</p> <p>Interview on 11/11/15 at 3:20pm with Resident #17 revealed: -She was aware she had orders for her blood pressure and blood sugar to be taken. -She refused to allow staff to take her blood pressure and fingerstick blood sugars because she did not want staff to take them.</p> <p>Telephone interview on 11/19/15 at 12:38pm with Resident #17's guardian revealed: -She had been guardian since June 2015. -The facility had not notified her that Resident #17 was refusing to have her blood pressure checked or FSBS obtained. -She had contact with the resident's mental health provider team but not regarding blood pressure check refusals or FSBS refusal.</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed: -The medication aides were responsible to let the mental health provider and medical health providers know of medication refusals. - "FYIs [for your information]" were sent to providers especially if medications were refused three days in a row. -If blood pressure medications were refused administration times should be changed for those residents.</p> <p>Refer to interview on 11/12/15 at 10:38am with a</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 96</p> <p>Medication Aide (MA).</p> <p>Refer to interview on 11/13/15 at 1:50pm with two dayshift MAs.</p> <p>Refer to interview on 11/13/15 at 2:40pm with a second shift MA.</p> <p>Refer to interview on 11/17/15 at 2:50pm with the Operations Manager.</p> <p>Refer to interviews on 11/18/15 at 9:35am and 3:00pm with the RCC.</p> <p>Refer to interview on 11/18/15 at 2:25pm with the facility's Primary Care Physician's Assistant.</p> <p>_____</p> <p>Interview on 11/12/15 at 10:38am with a Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -Residents could refuse medications or treatments at the medication room half door. -After a resident refuses to take medication or treatment offered 3 times, staff document the medication or treatment as refused. -Medication and treatment refusal was documented on the eMAR. <p>Interview on 11/13/15 at 1:50 pm with two first shift MAs revealed:</p> <ul style="list-style-type: none"> -They were not aware of a facility policy for notification of the physician for residents refusing medications or treatments. -The mental health provider team comes to the facility 2 to 3 times a week and reviews residents' eMARs when the team saw a resident. -Refused medications or treatments would show up on the eMAR. -Staff could document refused medications and treatments in the computer notes or in the facility "progress notes" that are entered manually. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 97</p> <p>-The Resident Care Coordinator (RCC) was not notified each time a resident refused medications or treatments.</p> <p>-Medications and treatments refused were sometimes documented on a telephone order sheet and put in the physician's box for notification, but not routinely.</p> <p>Interview on 11/13/15 at 2:40pm with a second shift MA revealed:</p> <p>-She had been working at the facility for 45 days.</p> <p>-She was not aware of the facility policy for notification to a physician if a resident refused medications or treatments.</p> <p>-She would inform the lead supervisor MA and document on the eMAR for refused medications or treatments.</p> <p>-She did not recall if she had ever notified a physician for refused medications or treatments.</p> <p>Interview on 11/17/15 at 2:50pm with the Operations Manager revealed:</p> <p>-"All the departments answered to her.</p> <p>-The Resident Care Coordinator oversees the clinical part of residents' care and if she has problems she comes to her.</p> <p>-Notification for medication refusals depends on the provider.</p> <p>-We call the physician for extensions on medication administration times when needed.</p> <p>-We don't always notify the physician because some (physicians) don't want to be notified all the time; Same with guardians who say they don't need to be notified every time a resident refuses their meds.</p> <p>-We don't have policy for medication refusals."</p> <p>Interviews on 11/18/15 at 9:35am and 3:00pm with the RCC revealed:</p> <p>-If residents refused medications or treatments</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 273	<p>Continued From page 98</p> <p>repeatedly, staff should document on the telephone order sheet and place in the doctor's box for the practitioner to sign with next visit.</p> <ul style="list-style-type: none"> -MA staff can also document in the progress notes manually (in a progress notes book), or in the electronic notes on the computer. -The notes, documented in the computer, are entered by shifts. -MAs can process shift notes that are sent electronically to the RCC, Operations Manager, and facility Nurse but not to the practitioner. -The RCC did not routinely audit resident records for refused medications or treatments and notification to the practitioner. <p>Interview on 11/18/15 at 2:25 pm with the facility's Primary Care Physician's Assistant revealed:</p> <ul style="list-style-type: none"> -He did not routinely review residents' eMAR for refusal of medication or treatments when he had an appointment with a resident at the facility. -The facility occasionally faxed over a notification of residents' refused medications or treatments. -The facility sometimes left a notification (filled out on a telephone physician order sheet) in the physician's box for review at the next 2 week scheduled visit. -The facility did not send notification for refused medications or treatments electronically (e-mail). -He expected the facility to notify him, by either faxing information or completing a telephone order sheet to be signed, when residents refused medications or treatments. -There was no documentation for refused medications or treatments for the residents in the office notes. <p>_____</p> <p>A Plan of Protection was discussed with the Operations Manager via telephone and requested from the facility on 12/15/15 at 4:15pm.</p> <p>_____</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 99 The violations identified are detrimental to the health, safety and welfare of residents as evidenced by the facility's failure to assure referral to mental health for Resident # 26, who was deemed incompetent and sexually active, and was not to be sexually active during a time period due to increased risk of pregnancy and following a medical procedure; assure mental health referral for Resident #21 with significant hoarding behavior; and notification of the physician for Resident #17 and Resident #22 regarding the residents' refusals of blood pressure checks and fingerstick blood sugar checks and medications. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2016.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received a complete set of flatware that included a knife and fork in order for residents to eat their	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 287	<p>Continued From page 100</p> <p>meals without having to wait for assistance from staff to cut up food or having to use their hands to eat food that could be not be cut or eaten with only a spoon.</p> <p>The findings are:</p> <p>Observation on 11/09/15 at 12:41pm of the lunch meal revealed:</p> <ul style="list-style-type: none"> - Not all residents entered the dining room at the same time. -There was an accumulative of 53 residents that entered the dining room. -The meal consisted of: mashed potatoes; green beans, ham, dinner roll, pears, water and milk. -All residents' place settings consisted of a spoon. -Five residents were observed to pick up their ham with their fingers to eat the meat. -Four residents were observed to use the side of the spoon with back and forth motions trying to cut the ham with the spoon. -At 12:43pm one resident revealed residents were never given a knife or fork to use when eating meals. -One staff was observed cutting two residents' ham using the spoon on the residents' plates. <p>Observation on 11/09/15 at 1:10pm revealed a resident sitting down at dining room table to eat. He was eating with his hands and only ate half a plate of food. His fingernails were dirty, jagged and green in color. He had food stains down the front of his sweatshirt.</p> <p>Interview on 11/09/15 at 1:10pm with the resident eating with his hands revealed he already had one plate of food and had turned in his spoon with the first plate when he finished. He could not get another spoon from staff so he ate with his</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 287	<p>Continued From page 101</p> <p>hands. He would have preferred to have had another spoon to eat with.</p> <p>Observation on 11/09/15 at 1:15pm revealed another resident trying to eat her ham slice, but was unable to cut it with the spoon. She requested assistance from the staff to cut her ham. Staff came over, used the spoon and her gloved hand to tear the ham apart.</p> <p>Confidential interviews with 5 residents revealed: -One resident said his ham was hard to cut using the spoon. -The resident said "they (staff) won't give us knives and forks around here, "They're afraid we'll stab each other." -"I have to pick up my food to eat it and I feel like an animal." -Two residents revealed it was easier to pick the ham up with their fingers to eat it, than it was to try and use the spoon to cut the ham. -The residents said they were never allowed knives or forks, so they did not ask. -A fourth resident said the meat today was really hard, even a plastic butter knife would help. -The resident stated if the surveyor was not in the dining room staff would not be assisting residents with cutting up their meat. -The same residents revealed if residents had asked that staff in particular to cut up their meats, the staff would have said "hell knoll." -A fifth resident revealed he never got a fork or knife. He had never observed a fork or knife being served. -The facility only gave out spoons, and it was hard to cut meat with a spoon.</p> <p>Interview on 11/09.15 at 12:58pm with the first shift Personal Care Aide (PCA) revealed: -She worked at the facility for 3 years and had</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 287	<p>Continued From page 102</p> <p>never served meals with a knife or fork. -She had heard that prior to her coming to the facility a resident stabbed someone with a fork. -If residents asked she assisted with using the spoon to cut-up their meat.</p> <p>Interview on 11/09/15 at 1:08pm with the Food Service Manager (FSM) revealed: -She had worked at the facility for 6 years and had never seen a fork or knife included in the place setting. -Knife and fork was never used in the facility, and there were none in the kitchen. -She had not observed residents eating with their hands. -It would have to be management decision to give the residents a fork and knife. -She had heard that prior to her employment a resident had stabbed another resident with a fork, so that was the reason those utensils were not served with the meal.</p> <p>Interview on 11/11/15 at 11:05am with the Operations Manager revealed: -Residents were not given a knife and fork for safety reasons. -In the past, prior to her employment at the facility, a resident stabbed another resident with a knife or fork. -Residents signed acknowledging they were not allowed a knife and fork. -The nurse practitioner or physician signed an order for residents not to have knife and fork due to potential harm it may cause.</p> <p>Review of 13 of 13 residents records revealed a preprinted form in with the admission forms. The form revealed the facility did not give residents knives and forks. The residents signed acknowledging the awareness they were not to</p>	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 287	Continued From page 103 receive a knife and fork as part of their place setting. Interview on 11/13/15 at 5:15 pm with the VP of Operations revealed: -Residents were never given a knife or fork for fear of hurting themselves or someone else. -Residents had orders not to give the knife and fork because it could potentially be harmful.	D 287		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview, observation and record review, the facility failed to assure at least 14 hours of planned group activities were provided each week for the residents that promoted socialization, physical interaction, group	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 317	<p>Continued From page 104</p> <p>accomplishment, and learning of new skills.</p> <p>The findings are:</p> <p>Interview on 11/9/15 at 10:45am with the Operations Manager revealed there were 69 residents who resided in the facility.</p> <p>Review of the facility's November 2015 activities calendar revealed the following activities were scheduled:</p> <ul style="list-style-type: none"> -11/8/15, 1:30 store 1 hour. -11/9/15, 11:00 coloring 1 hour, 1:30 store 1 hour, 2:30 puzzles 1 hour. -11/10/15, 11:00 letter writing 1 hour, 1:30 store 1 hour, 2:30 games, chess, checkers, Uno, monopoly 2.5 hours. -11/11/15, 1:30 store 1 hour, 3:00 bingo, 1 hour, 4:00 bible study. -11/12/15, 9:30 store stock 4 hours, 1:30 store 1 hour, 4:00 word search. -11/13/15, 11:00 letter writing 1 hour, 1:30 store 1 hour, 4:00 disc golf 1 hour. -11/14/15, 1:30 store 1 hour. -11/15/15, 1:30 store 1 hour. -11/16/15, 11:00 coloring 1 hour, 1:30 store 1 hour, 2:20 word search 1 hour. -11/17/15, 11:00 trivia 1 hour, 1:30 store 1 hour, 3:00 library trip 2 hours. -11/18/15, 1:30 store 1 hour, 3:00 bingo 1 hour, 4:00 bible study. -11/19/15, 1:30 store 1 hour, 4:00 Gilligan's Island 1 hour. <p>Review of the November 2015 activities calendar revealed games, chess, checkers, Uno, monopoly, 2.5 hours was listed as the activity on 11/10/15 at 2:30pm.</p> <p>Observation on 11/10/15 at 2:30pm of the</p>	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 317	<p>Continued From page 105</p> <p>employee back office revealed the Assistant Operations Manager moving large black plastic bags of clothing to the room.</p> <p>Interview with the Assistant Operations Manager on 11/10/15 at 2:30pm revealed the facility had received bags of free clothing from a local thrift store that had gone out of business.</p> <p>Further interview on 11/13/15 at 3:15pm with the Assistant Operations Manager revealed there had been no activity on 11/10/15 at 2:30pm due to the thrift store clothing donation. On average he tried to schedule between 20-25 hours of activities per week. This allowed for flexibility to address unforeseen issues, like the clothing donation.</p> <p>Observation on 11/11/15 at 2:55pm revealed: -Numerous residents seated or gathering in the main dining room for bingo. -No staff were present in the dining room.</p> <p>Observation on 11/13/15 at 11:00am revealed the Assistant Operations Manager seated at a table in the dining room working on a puzzle. The Housekeeping Supervisor was seated at the table. No residents were seated at the table working on the puzzle.</p> <p>Interview with the Assistant Operations Manager on 11/13/15 at 11:00am revealed puzzles had been substituted for the letter writing activity listed on the activity calendar. He provided no indication to reason residents were not participating in the activity.</p> <p>Observation on 11/13/15 at 4:20pm of 9 residents playing a Frisbee game led by staff. The activity ended at 4:35pm.</p>	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 317	<p>Continued From page 106</p> <p>Observation on 11/16/15 at 3:30pm revealed: -Ten residents in the dining area were working on word search puzzles. -One resident commented she would receive cigarettes for participating in the activity.</p> <p>Observations during the survey on 11/10/15, 11/11/15, 11/13/15, 11/17/15 and 11/19/15 revealed residents would be in a single-file line that extended down the 400 hallway, adjacent to the store (in-house commissary where residents could purchase snacks, sodas, sundry items, etc), beginning at approximately 1:00pm each day. While in line, residents were observed sitting on the floor or leaning against the wall waiting for the store to open. Residents were observed at the door of the store, one resident at a time, selecting from products that included soda, cereal and an assortment of candy.</p> <p>Random interviews with 23 residents during the survey from 11/9/15 to 11/16/15 revealed: -Four residents reported playing Frisbee golf. -Seven resident reported playing bingo. -Two resident reported they sometimes played card games like rummy or spades. -One resident stated the Activity Director (Assistant Operations Manager) "didn't do a lot of activities with us. He wanted us to color all the time. We don't want to color, we want to do other things". -Once a month residents could go to a department store and once a week to a nearby convenience store. -One resident stated if a resident smoked in a room and set off the fire alarm, each false alarm costs the facility \$150 which meant there was no money to go to "baseball." -Two residents indicated they did not participate in activities by choice.</p>	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 317	<p>Continued From page 107</p> <p>-Three residents indicated there were no activities that interested them.</p> <p>Interview on 11/16/15 at 2:00pm with the Assistant Operations Manager revealed:</p> <ul style="list-style-type: none"> -Every six months the residents received an activity survey for input and satisfaction. -Highlighted comments meant the suggestion was "feasible". -Suggestions marked with a check-mark were implemented. <p>Review of the Activity Review #2 2015 form used to survey residents revealed:</p> <ul style="list-style-type: none"> -There was no date indicated on the form as to when it was completed. -27 residents completed the form. -There was a list of current activities as indicated on the November 2015 calendar with a numeric ranking system, a question asking for other activities residents would like added and how to improve the current activities provided at the facility. -Highlighted (feasible) suggestions included dances, walking weather permitting, trips to two fast-food restaurants, making jewelry, bowling, have a day reserved that is open and have residents pick the activity, "take us out more," dominoes, karaoke, activities on weekends. -Suggestions with a check-mark (implemented) included activities on weekends, movies, movies with snacks. -Suggestions without a check-mark or highlight included swimming, water activities, more trips to local department store, have better sodas in the store, cooking class, more shopping trips, parties, fairs, musical chairs, appreciate the recognition of people that go to work, take pictures of the resident of the month. 	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 317	<p>Continued From page 108</p> <p>Review on 11/13/15 at 3:25pm of the November 2015 monthly activity calendar with the Assistant Operations Manager for the week of 11/8/15 through 11/14/15 revealed:</p> <ul style="list-style-type: none"> -There was 7.5 hours of activities scheduled for coloring, puzzles, letter writing x 2, games (chess, Uno, checkers, monopoly), word search, disc golf and bible study (no duration of this activity listed). -There was 7 hours listed as store (one hour each day). -Four hours was listed as store stock. <p>Interview on 11/13/15 at 3:15pm with the Assistant Operations Manager revealed:</p> <ul style="list-style-type: none"> -He was responsible for the activities program including the facility store. -He had been working at the facility since February 2015. -He had a degree in Outdoor Ministry. -He knew of the required rule to provide at least 14 hours of activities per week. -On average he tried to schedule between 20-25 hours per week. This allowed for flexibility to address unforeseen issues, like the recent clothing donation he had facilitated (on 11/10/15). -The time listed on the calendar was a "soft" time, meaning the activity might run longer and at times run shorter. -There was no documentation for who participated in each activity or the time and duration of the activity. -Each week he tried to have two or three new activities. There were certain activities always scheduled, such as bingo. -There were activities that offered prizes, snacks, cigarettes. -He found it difficult to find activities residents wanted to do. Some residents only participated when there were prizes for the activity. Some residents liked to color and others did not. 	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 317	<p>Continued From page 109</p> <p>-Outings included going shopping, weekly trips to local convenience stores, the library, local street fairs and a local (fraternal service organization) event.</p> <p>-He had a \$100 monthly activity budget.</p> <p>-He considered the store a socialization activity.</p> <p>-The four hour store stock listed on the activity calendar on Thursday's at 9:30am was not an activity. It was listed so residents knew he was busy during that time.</p> <p>Observation on 11/16/15 of December 2015 activity calendar revealed store stock, 4 hours, was not listed as an activity.</p> <p>_____</p> <p>A Plan of Protection was discussed with the Operations Manager via telephone and requested from the facility on 12/15/15 at 4:15pm.</p> <p>_____</p> <p>The violation identified is detrimental to the health, safety and welfare of residents as evidenced by lack of planned group activities to promote socialization, physical interaction, group accomplishment, and learning of new skills.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2016.</p>	D 317		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 110</p> <p>TYPE A1 VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to protect residents from abuse, neglect, and exploitation by failing to protect residents from physical assaults resulting in injury to residents; by admitting residents with aggressive, and dangerous behaviors; by failing to discharge residents with aggressive, and dangerous behaviors; by implementing a resident work program that was used as a tool for discipline and coercion and for which residents were not given fair or equitable compensation for work completed that benefited the facility; by failing to properly maintain and repair durable medical equipment for four residents (#7, #8, #19 and #20); by failing to manage a resident's hoarding behavior which resulted in a safety hazard and cockroach infestation in the resident's room; and neglect by failing to provide a plan to ensure 2 of 2 sampled residents (#3 and #6) with diminished mental capacity were engaging in safe sex practices and with consent.</p> <p>The findings are:</p> <p>Review of the resident census provided by the facility on 11/9/2015 revealed there were 69 residents currently residing in the facility.</p> <p>Interview on 11/17/15 at 2:55pm with the Vice President of Operations revealed there "were about 30" residents at the facility who received mental health services from the on-site mental health provider.</p> <p>Review of 26 resident records revealed 22 had at least one mental health diagnosis.</p> <p>Observation of the facility during the various days</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 111</p> <p>and times of the survey revealed:</p> <ul style="list-style-type: none"> -All resident rooms are located on one straight hallway. -Hallways and common areas were compromised of hard surface flooring throughout the facility. Hallways and common areas were painted in a monotone, neutral beige color, and no furnishings were observed on the walls except for numerous video cameras and wiring lining the tops of the walls. -There was a constant flow of residents walking up and down the hallway, gathering in the TV area adjacent to the dining room, moving to and from the smoking areas at each end of the building and two locations on the front of the building. -Residents were observed lined-up in the hallway at meal times, medication times and store times. -Residents were observed sitting in chairs or on the hallway floor outside of the Operations Manager's office waiting to speak with her. -Medication aides and management staff were in offices or medication rooms and seldom observed on the hallway. <p>Interview on 11/17/15 at 2:50pm with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -The facility received admissions referrals by fax or phone. -The FL2, history and physical are reviewed, talk to the social worker at the hospital, talk to the previous facility, if applicable, and talk to families to determine as to if a good fit for the facility. -"I do a face-to-face with the resident if they have never been here before." -If they have been here before with no problems then will readmit. -We stay away from residents with previous assaults and/or personal altercations. -Also depends on what and when it occurred, if it 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 112</p> <p>happened years ago and no current problems then we will take them.</p> <p>-The (Vice President of Operations) helped her with the assessments but "leaves the final decision up to me".</p> <p>-"Reasons we discharge" are for aggressive behaviors, when residents were not using the mental health resources or not working with psychotherapy, refusing medications, outbursts, putting themselves or others in danger.</p> <p>-"When I've used all my resources, then I have to discharge."</p> <p>-If a resident had a bad altercation, repeated altercations or several involuntary commitments and were no better then, this also would be a reason for discharge.</p> <p>complaints from residents or families about care and services.</p> <p>A. Review of McDowell County Sheriff's communications call log revealed a total of 202 calls from 5/2/15 through 11/5/15 (approximately six months) made from Cedarbrook Residential Care Facility to the McDowell County Sheriff's Office. Further review of the call log revealed:</p> <p>-70 calls made for resident medical issues such as seizures, falls, diabetic problems, chest pain, and unconscious resident.</p> <p>-41 calls made for missing residents or residents who had walked off/away from the facility.</p> <p>-26 calls made for physical assaults and fights between residents. Two of these calls were for physical assaults between a resident and staff member.</p> <p>-18 calls made for activation of the fire alarm, several noted the reason being smoking inside of the facility in resident rooms and bathrooms.</p> <p>-16 calls made for Involuntary Commitment (IVC) of residents.</p> <p>-The remainder of the calls were related to</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 113</p> <p>various issues including theft (3 calls), resident suicide attempt (2 calls), illegal drug activity (1 call), and general.</p> <p>Review of facility's Accident/Injury reports revealed from 5/5/15 to 11/16/15 there were 50 reports pertaining to verbal, physical or sexual altercations or assaults.</p> <p>Random interviews with 18 residents from 11/9/15 to 11/19/15 revealed:</p> <ul style="list-style-type: none"> -A resident stated he had been attacked during the night (could not say which night) and punched in the chest and back. He thought the attack may have been "pay back" but was not able to explain. -One resident stated he had been struck by the same resident two different times with a soda can. He stated one of the times he received stitches. He stated he and the other resident were fine now. -"This place [facility] is more carefree and had not as many rules and guidelines. Had drama like fights, drug busts and prostitution sex." -"Staff refused to give a resident a sandwich and I was sitting next to him and he hit me taking his anger out on me." -A resident threatens me and the staff didn't do anything about it. -Some days I don't feel safe here because of the threats and fights. -One certain resident likes to fight and he bangs on doors. Staff calls crisis but it doesn't help. -One resident said "I don't feel secure at all." -Two residents got in a fight yesterday (11/15/15). Two staff witnessed the fight. -One resident tried to "jump on" him about six months ago. The resident came running across the yard cursing and jumped on him. He tried to defend himself. -They (residents) fight all the time. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 114</p> <ul style="list-style-type: none"> -Some residents fight over "weed," boyfriend, girlfriend or for no reason. -One resident sold coffee on credit and if people don't pay he wanted to fight them. -A female resident stated a male resident at the facility hit her because he did not want to eat the meal, he wanted a cheese sandwich. The male resident threatened her, saying he was going to punch her again. She told staff and staff said to just "brush-it off". Resident (male) tries to fight females, staff calls crisis hotline. The same male resident choked her once, because she got into an argument with his girlfriend. -A resident stated they "have lots of things that escalate, mostly shouting matches". -One resident reported "[another resident] beat somebody up real bad, hitting them on the head. I actually saw that". The altercation occurred around supper time. -Another named resident was caught eating "cake" and drinking a soft drink of his. The resident stated that he tried to "kick him [the other resident] in the face" but he could not get his leg high enough. He had grabbed the other resident by the hair. Staff followed him and tried to "break things up". He let go of the other resident's hair. <p>Interview on 11/16/15 at 3:52pm with a Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> -He started employment at the facility in September 2015. -When residents got in an altercation, he tried to separate quickly. -He stated he informed the staff Medication Aide (MA) about a fight or altercation. -He stated he had not had to break up a fight. -He stated two named residents had an altercation last night (11/15/15) in the dinner line. He got there when the altercation was already over. He stated one resident sucker punched the 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 115</p> <p>other resident in the chest. The resident that was punched was not injured.</p> <p>-The resident that did the punching is not usually a resident who gets upset, but the facility took his coffee and cigarettes away according to the "State".</p> <p>-He stated "until it (arguments or confrontations) came into the hallway, the staff cannot do anything about the resident's interactions".</p> <p>-He stated the facility should have classes on diffusing situations.</p> <p>Interview with a Personal Care Aide on 11/16/15 at 3:55PM revealed:</p> <p>-During resident altercations he would "very carefully" diffuse the situation.</p> <p>-He would separate everyone and make the supervisor aware.</p> <p>-He would make a verbal statement of what he saw to the supervisor.</p> <p>-The previous night he arrived in the hallway after two named residents had an altercation.</p> <p>-One of the named residents "sucker punched" the other in the chest who "had wind knocked out".</p> <p>-The one resident who did the punching normally did not behave like this but this resident had coffee and cigarettes taken from him.</p> <p>-Two other named residents had a brief altercation.</p> <p>-"I am learning real quick who likes who."</p> <p>-"There is nothing we can do, they have rights. We have no right to open a door, no idea what they talk about behind closed doors."</p> <p>Telephone interview on 11/19/15 at 4:06pm with a local law enforcement deputy revealed:</p> <p>-He had been working as a deputy for 12 years and had responded to calls at the facility "since day one".</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 116</p> <ul style="list-style-type: none"> -Most of the 911 calls were for fighting and residents walking away from the facility, "they walk away a lot". -The staff are just there, they are not much of a help. -Residents who are out of control usually are involuntarily committed to a local hospital by the crisis response team. -"You name it, residents will fight over it." -About a month ago two male residents were fighting over the same female resident. The Magistrate won't allow residents to press charges against another resident; they have to call the crisis response team. -A deputy will respond when emergency medical services (EMS) responds to a call at the facility. <p>Telephone interview on 11/19/15 at 4:17pm with a second local law enforcement deputy revealed:</p> <ul style="list-style-type: none"> -He had responded multiple times to calls at the facility. -Although it had seemed he had responded to calls at the facility "every day," there had not been any calls from the facility the "past two weeks". -"Personally, they don't have a good hold on their people (residents). We have to do their (staff) job all the time." -He did not believe staff ran the facility correctly. -He knew of other residential facilities in the county, "this place is the only place we get called to". <p>Telephone interview on 11/20/15 at 1:11pm with a third local law enforcement deputy revealed:</p> <ul style="list-style-type: none"> -The number of calls from the facility was "almost ridiculous". -Staff have been told to call 911 before calling their supervisor for residents with aggressive behaviors. -When there were resident to resident assaults 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 117</p> <p>staff would look to involuntarily commit a resident.</p> <p>-Local law enforcement transported residents to the magistrate's office for an involuntary commitment. The behavior described by the facility staff did not always match the residents' behavior, the aggressive or out of control behavior was not being seen by the deputy officer.</p> <p>Interview on 11/17/15 at 2:52pm with the Resident Care Coordinator (RCC) revealed:</p> <p>-If residents were engaged in inappropriate behaviors like screaming and fighting, they were redirected if possible.</p> <p>-After referring to a list of what resident was assigned to what mental health service, the crisis team could be called, along with management and the guardian.</p> <p>-If residents were fighting, staff would call 911 if they were unable to stop the fighting, which they were told by one mental health service to do as there was a "faster response".</p> <p>Interview on 11/17/15 at 2:50pm with the Operations Manager revealed:</p> <p>-How the facility responded to an altercation depended on situation.</p> <p>-If just verbal then staff tried to redirect residents without any other interventions, "I would try to intervene when possible".</p> <p>-If psych(iatric) issues, then (staff) would call mobile crisis.</p> <p>-If violent then we call law enforcement.</p> <p>-If someone (resident) gets hits, the resident can press charges at the Magistrate's office. That is their right.</p> <p>-If staff called me and told me the resident was not at baseline then I would come to the facility to determine what to do.</p> <p>-We would do an Involuntary Commitment (IVC) if</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 118</p> <p>needed. If IVC is needed, then we notified the guardian/responsible person, mobile crisis and the RHA for those with mental health services.</p> <p>-We would also notify the provider to come out to do an assessment. I can't do assessments.</p> <p>-If the provider felt like an IVC is needed, they would contact the Magistrate for an IVC order.</p> <p>-The Magistrate preferred for the resident to have a mental health assessment if we ask for an IVC order.</p> <p>-Sometimes they are admitted to the hospital, it depends on the emergency room (ER) doctor.</p> <p>-Sometimes they came back if the ER doctor determines they didn't meet the criteria to be admitted.</p> <p>-We tried to look at how to prevent the behaviors or what is causing them. Is there a staff person upsetting the resident? Is another resident upsetting them? Is something bothering them? I tried to figure out what is going on with them by talking to them. Is this (behavior) out of the norm for the resident, if so then we send them to the ER.</p> <p>-They (ER) would do a psych(iatric) eval(uation) and determine if they are ok to return.</p> <p>-We try to work with the guardians as well to try to find out what the problem is.</p> <p>-When we call the law enforcement when there is a problem, they would tell us to call mobile crisis, it's a psych(iatric) issue. Mobile crisis would tell us to call law enforcement, it's a criminal law issue.</p> <p>Observation during interview on 11/17/15 at 3:30pm with the Operations Manager revealed:</p> <p>-Resident #18 and another resident began yelling at each other outside of the Operations Manager's window. They were cursing at one another and yelling, "get out of my face and leave me the (expletive word), alone. If you don't get</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 119</p> <p>away from me, I'm going to knock your (expletive word) head off".</p> <p>-The Operations Manager got up and looked out the window and excused herself to go intervene.</p> <p>-Another staff person also responded to the verbal altercation within less than a minute.</p> <p>-Upon return the Operations Manager stated, "the other resident got in Resident #18's space and was asking for a cigarette. We redirected both residents and calmed them down".</p> <p>Second interview on 11/19/15 at 9:55am with the Operations Manager revealed:</p> <p>-Physical altercations between residents tended to happen at the end of the month when residents are running out of money and cigarettes, their agitation increases.</p> <p>-When people are in a common area together there is more of an opportunity for things to happen.</p> <p>-She looks to employ strong supervisors to work second shift. Someone who is capable of managing and responding to an altercation between residents, or other behaviors.</p> <p>B. Review of Resident #2's FL2 dated 8/3/15 revealed diagnoses of schizophrenia, hyponatremia and hypocalcemia.</p> <p>Review on 11/10/15 of Resident #2's record revealed:</p> <p>-Date of admission 8/11/15.</p> <p>-Date of discharge 10/28/15.</p> <p>-Resident came to the facility from a facility that was closing.</p> <p>-Referral for mental health services.</p> <p>-Resident was a smoker.</p> <p>Further review of Resident #2's record revealed a notice of discharge form that indicated resident</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 120</p> <p>admitted to setting fire to linens in 400 hall bathroom on 10/27/15. Resident discharged on 10/28/15 to local law enforcement.</p> <p>Telephone interview on 11/25/15 at 9:59am with the Deputy Director of the local Emergency Management Service revealed:</p> <ul style="list-style-type: none"> -He conducted the fire investigations in the county and had conducted the investigation at the facility. -The facility called him on 10/28/15 because they had reviewed their camera recording and noticed residents in the vicinity of the 400 hall bathroom around the time of the fire. -Through conversation (Resident #2) admitted to setting fires when he became upset or agitated. -During the investigation he spoke with a neighboring county fire investigator and learned that (Resident#2) was a person of interest for them with setting fires in their county. -He was "glad" the facility discharged Resident #2. <p>Interview on 11/30/15 at 11:10am with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -Resident #2 was a smoker. -She was not aware if Resident #2 had a history of setting fires prior to admission. -She became aware of his history following a telephone call with a family member on 10/28/15. -She was not aware if Resident #2 had been on smoking restriction at the time of the incident or at any time during his stay at the facility. -Resident #2 smoke breaks would have been supervised only when he was on smoking restriction. -When interviewed by law enforcement, Resident #2 stated he used a lighter to set the fire. -When on smoking restriction the resident's lighter was kept in the medication room, yet the resident could still borrow a lighter from another 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 121</p> <p>resident.</p> <p>-When the fire department responded to a fire and they determined the fire to be suspicious, the fire department would contact local law enforcement.</p> <p>-The facility would not admit anyone with a known history of setting fires. She would receive information from all available sources, guardians, social workers, family, other facilities, in order to make an informed decision on admitting a resident.</p> <p>-She had spoken with the facility Resident #2 was transferring from and received no information regarding fire setting behaviors.</p> <p>-Resident #2 had mental health services but would have to access his record for specifics.</p> <p>-The facility used the rules for adult care homes for admission and discharge guidance.</p> <p>Telephone interview on 11/25/2015 at 12:31pm with a detective from the McDowell County Sheriff's Office revealed:</p> <p>-Resident #2 intentionally set a fire in the facility on 10/27/2015 and the fire department responded.</p> <p>-The facility did not contact law enforcement until 10/28/2015.</p> <p>-Law enforcement arrested Resident #2 on 10/28/2015.</p> <p>-The facility was aware that Resident #2 had been suspected of setting fires in the facility where he previously lived.</p> <p>-Police interview notes revealed that the facility's Vice President of Operations told law enforcement on 10/28/2015 that the facility was advised by Resident #2's former facility that they had dealt with Resident #2 and fires at their facility.</p> <p>-The detective considers Resident #2 to be very dangerous.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 122</p> <p>Interview on 11/30/15 at 11:32am with the Vice President for Operations revealed:</p> <ul style="list-style-type: none"> -She had spoken with the administrator at the facility Resident #2 was transferring from prior to accepting him. -The administrator indicated a resident that had already been discharged was responsible for fires at their facility and not Resident #2, "(Resident #2) not one of the prime suspects". -Depending on the circumstances, history and treatment, they would consider admitting a resident with a fire setting history. The screening process is the same for any prospective admission. -The facility used the rules for adult care homes for admission and discharge guidance. -On 10/28/15 she viewed the camera footage of the 10/27/15 incident and called the emergency medical services director due to Resident #2 being in the area of the fire and because Resident #2 had been very verbal about specifics of the fire, "he seemed to know too much" about what had happened. -Per the fire department report of the 10/27/15 incident, they (the fire department) had contacted the fire investigator. -Resident #2 had mental health services but would have to access his record for specifics. <p>Review of the local fire department's report dated 10/28/15 revealed:</p> <ul style="list-style-type: none"> -They received and responded to a fire alarm from the facility on 10/27/15 at 10:15pm. -Upon arrival at the facility staff had reported the fire had been extinguished and was located in the bathroom on 400 hall. -The staff reported all residents were accounted for and had been evacuated from the building. -Cause of ignition was intentional. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 123</p> <p>-Fire department personnel did not have a suspect and the scene was turned over to the local county law enforcement office and emergency medicine service for further investigation into the arson case.</p> <p>-Fire department personnel were on-site from 10:20pm to 11:03pm.</p> <p>C. Various interviews with residents revealed that some residents "work" at the facility.</p> <p>Review of the facility's written summary description of the resident activity work program (AWP) revealed the AWP is a voluntary resident activity designed to help residents feel good about themselves by participating in positive activities. The reward for participation in these activities is a feeling (of) accomplishment and a small credit in the "company store" to purchase sodas, snacks and other small items. The activity is totally voluntary and the productive "work" is "negotiated" between our activity director and the resident and can include most anything from coloring pictures to put on bulletin boards, helping purchase soda's at the "company store" or sweeping outside from point A to point B and back to point A. The requirement to participate in this activity is the activity must be accomplished as agreed and the accomplishment must be verified by signature of a staff member, and turned in to the activity department.</p> <p>Review of the current AWP resident duty roster revealed:</p> <p>-44 residents were listed as participating.</p> <p>-Duties included: end 400 smoking area cleanup, 300 smoking area, linens, wipe rails, windows kitchen, kitchen trash, nightly cleaning, window sills dining room, trash, clean 200 hall, trash and rails 200, floors, dayroom smoking area, railings</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 124</p> <p>his hall (hall resident lived on), 200 dayroom wipe down, floors, move furn kit, basketball area, lunch trash, med dayroom furniture, dining room setup, Wednesday box trash, move furniture 300 dayroom, kitchen, 100 dayroom, decorations, trash dinner, floors/act, Pepsi guy, act clean, store cart, keep it up, raking sides, behavior.</p> <p>Random interviews with five residents regarding the work store credit revealed: -One resident said the work credit wasn't right, because she got mad and cursed out the Resident Care Coordinator (RCC), so they took away \$2.00 from her \$5.00 she earned. -A second resident said work credit was if you do something they don't like, they will take store credit away. Once he laughed when someone got assaulted and \$1.00 of the \$5.00 store credit was taken away which made him feel powerless and deflated. -A third resident stated he gets \$5.00 store credit. If he get caught smoking or doing things, some of that (credit) will be taken away. -One resident stated if a resident smokes in a room and sets off the fire alarm, each false alarm costs the facility \$150 which meant there was no money to go to "baseball". -Another resident revealed he worked outside for about 2 hours a day. No one kept track of hours worked. Every Thursday he received a "store credit" worth \$5.00. He did the work "just to have something to do". "I volunteered." "If I need cigarettes they (staff) will help me."</p> <p>Interview on 11/9/15 and 11/11/15 with a resident revealed: -She worked at the facility, sweeping and picking up cigarette butts, for which she received a \$5.00 "credit at the store". -Other tasks she did was to "pick up sticks," "pick</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 125</p> <p>up trash" and "help [administrator] in the office". -"The \$5 store credit is not enough for what I do." -"I keep track of my time." -She started "chores" about 8:30am and got them done at 12:00pm. -Her chores included "sweeping in trailer, "sweeping outside and in the dining room and to "feed the cat." -"I just help out" and "I get \$5.00 store credit." -She had asked the Operations Manager for a raise but she was not given an answer. -"They want me to do more." -"I need money so I can see my son". -"They have no one to work on weekends" and "sometimes ask me to work to 4:30(pm)". -On weekends she swept and collected cans, "I don't get any of the money" (for the cans).</p> <p>Observation on 11/10/15 at 10:00am revealed a resident in his wheelchair sweeping the asphalt parking area directly in front of the entrance doors to the facility, placing leaves in piles.</p> <p>Observation on 11/12/15 at 8:25am revealed: -A female resident carrying a small white bucket and rag. -The resident told the Housekeeping Supervisor "I did my chore". -The Housekeeping Supervisor asked the resident if she "wrote it down" to which she replied yes proceeded to walk down the hallway. -The Housekeeping Supervisor told the resident that today was "payday".</p> <p>Interview with the Housekeeping Supervisor on 11/12/15 at 8:25am revealed: -The resident's "chore" was to wipe down chairs in a specific area (he did not identify which area). -He stated it was "good" for residents to "have something to do".</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 126</p> <p>Observation on 11/12/15 at 8:35am revealed a male resident pushing a dust mop through the common area on the 400 hallway then down the hallway.</p> <p>Interview on 11/12/15 at 8:35am with a resident revealed: -He worked 4 hours each morning, 5 days a week. -He liked to work and got a \$5.00 store credit to "buy cigarettes and sweets and cake".</p> <p>Second interview with the Housekeeping Supervisor on 11/12/15 at 9:30am revealed: -The resident had been dust mopping since the Housekeeping Supervisor arrived 7 years prior, but only for 1 hour each day. -The resident received his "incentive pay". -Residents get a chore and they could refuse to do it but they still received their "incentive pay". -He stated today was "payday" where residents could go to the store to "get their cigarettes". -No money was passed at the store, it was "all on credit".</p> <p>Observation on 11/12/15 at 2:15pm of a resident revealed: -She holding a dust pan and a broom. -She was standing outside of her room.</p> <p>Interview on 11/12/15 at 2:15pm with the resident revealed: -She had been "working" but needed to check on her room. -A housekeeper "harasses" her to work. -She documented the hours that she worked.</p> <p>Review of the resident's documented hours from a spiral bound notebook revealed:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 127</p> <ul style="list-style-type: none"> -Days of the week and the date noted (sample reviewed was for Thursday, 10/22/15 through Thursday, 11/12/15). -Next to each day and date is the time 8:30 and "clean up" and "bag cans". -Next to "clean up" and "bag cans" are the times of either 4:00, 4:30, 5:00 or 5:30. -On the right side of the pages next to entries for 11/3/15, 11/4/15, 11/5/15, 11/9/15, 11/10/15 and 11/11/15 is the name of the Operations Manager. <p>Observation on 11/18/15 at 9:10am revealed:</p> <ul style="list-style-type: none"> -A housekeeper mopping the floor. -A male resident standing beside a large round fan. -As the housekeeper mopped down the hallway, the male resident would move the fan. -The fan was blowing air onto the wet floor. -The fan was not turned off when the resident moved the fan. -The resident would tip the blowing fan onto the wheels and push towards the housekeeper. <p>Interview on 11/18/15 at 9:15 with the resident revealed:</p> <ul style="list-style-type: none"> -"I do this every day." -"I'm helping (housekeeper's name) to dry the floors and supervising him." <p>Interview on 11/12/15 at 3:00pm with a Housekeeper revealed:</p> <ul style="list-style-type: none"> -All residents have an "AWP" (he could not define the acronym) where they get \$5.00 for different "tasks". -"Chores" were voluntary, not done on weekends and should take no more than 5 to 10 minutes to complete, not hours. -One resident swept "all day long" but had been told she did not have to do that. The resident would get upset because she is not getting more. 	D 338		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 128</p> <p>The resident would slide a detailed list of her times under the door of the Operations Manager's office.</p> <ul style="list-style-type: none"> -Every Wednesday a "checklist" for AWP is reviewed as behaviors can affect their credit. -Residents unable to do chores are "accommodated". -"Bad behavior," like "cussing" would not take all the resident's credit away. <p>Interview on 11/17/15 at 2:52pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -Resident chores were "voluntary" for which they were given \$5.00 credit a week in the "store". -Some residents just do chores (mentioning a resident by name). -The mental health provider had not recommended that residents perform chores. -Not every resident did chores and the number that did do chores was not many. <p>Interview on 11/17/15 at 2:50pm and 11/18/15 at 9:25am with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -"We allow them to choose what they want to do to allow them something to do". -"It is an activity work program and voluntary. " -The Assistant Operations Manager was responsible for the AWP program. -It can be as simple as coloring a picture for me, meeting with me concerning what the residents like or don't like. -We looked at what they are suited to do. -One resident colored pictures for me. -One of the residents was in a wheelchair now and was not able to do anything but we give her store credit because she used to be very involved here. -The Assistant Operations Manager did the store credit as a reward if the resident didn't have any outbursts that week. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 129</p> <ul style="list-style-type: none"> -If they did have an outburst then the store credit was reduced. -It (store credit) was used as a behavioral intervention. -The Assistant Operations Manager checks with me to see if anyone has had any outbursts or problems the week before giving the credits. -The Assistant Operations Manager was the head of the program. -One resident liked to hang with housekeeping and "supervise them". -Another resident gave me ideas what other residents liked to do. -Another resident helped the Assistant Operations Manager with games. -Whatever helped them (residents) to be involved. <p>Interview on 11/18/15 at 1:15pm with three staff members from the local mental health service provider revealed they had no knowledge of the AWP program or how it was operated. The AWP was not part of any of the residents' treatment plans.</p> <p>Interview on 11/18/15 at 5:00pm with the Assistant Operations Manager revealed:</p> <ul style="list-style-type: none"> -He had taken over the AWP upon hire this past February. -The residents spent their life in the building, day after day, and AWP provided residents with an opportunity to "do something" during the day, up to five hours per week. -The tasks for the residents were tailored towards their ability, interests and availability. -One resident enjoyed decorating the building, one pushed the store cart down the hall each day from the activity office to the store, another breaks down cardboard boxes following a food truck delivery, one resident supervised the 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 130</p> <p>housekeeping manager.</p> <p>-Store credit was based on the resident's "willingness to do things".</p> <p>-When a resident signed-up for the program they learned they would lose store credits for fighting (\$2) or "cursing staff, going off" (\$1).</p> <p>-This was used as a de-escalation tool for residents, "remember your store credits " or as an incentive program for smokers.</p> <p>-\$5.00 per week went a long way in support of their \$66 monthly personal fund amount.</p> <p>-There were 44 residents signed-up in the AWP.</p> <p>-Each resident was given a specific task and depending on the task, a specific area, such as sweeping the smoking areas, wipe down windows sills or cushions in a dayroom, one resident dry mops the hallway floors. This was one benefit of the program (residents completed tasks that otherwise would be completed by staff), not its purpose.</p> <p>-The purpose was to give them something to do that made them feel productive and build their self-confidence.</p> <p>D. 1. Review of Resident #7's most current FL-2 dated 7/7/15 revealed:</p> <p>-Diagnoses which included chronic obstructive pulmonary disease, schizoaffective disorder and degenerative joint disease (DJD) of the knees.</p> <p>-Ambulatory status was not checked.</p> <p>-Ordered medications included fluphenazine (an antipsychotic medication used to treat schizophrenia), olanzapine (another antipsychotic medication), and lorazepam (an antianxiety medication) as needed.</p> <p>Review of Resident #7's assessment and care plan dated 7/16/15 revealed:</p> <p>-He had a guardian.</p> <p>-He was assessed as ambulatory with an aide or</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 131</p> <p>device, with "walker with wheels" (also called a rollator) written in.</p> <p>-In the care plan the activity of ambulation/locomotion was pre-printed but there was no performance code noted.</p> <p>-The assessment/care plan was signed by the Resident Care Coordinator (RCC) and the primary care provider.</p> <p>Review of Resident #7's most recent Licensed Health Professional Support (LHPS) note dated 8/24/15 revealed:</p> <p>-The only pre-printed LHPS task that was checked was "medication admin[istration] through injection."</p> <p>-The pre-printed LHPS task of "ambulation using assistive devices" was not checked.</p> <p>-"The care plan indicated that he is ambulatory with a rolling walker."</p> <p>-"Resident is observed ambulating outside with a rolling walker."</p> <p>Review of provider orders for Resident #7 dated 8/28/15 and signed off by the provider on 8/31/15 revealed "rolling walker w [with]/seat attachment."</p> <p>Review of a facility accident/injury report on Resident #7 dated 8/30/15 revealed:</p> <p>-The resident left the medication room window "walking extremely fast."</p> <p>-Before the staff could get to him the resident's walker "came away from him" and the resident fell to the ground.</p> <p>-The resident complained of pain to his knee, hip and wrist.</p> <p>-The resident was taken by Emergency Medical Services to the ER on 8/30/15 at approximately 9:30pm.</p> <p>Review of an ER report on Resident #7 signed by</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 132</p> <p>the doctor on 8/31/15 revealed:</p> <ul style="list-style-type: none"> -The resident came "from his nursing facility after falling while walking with a broken walker." -The resident fell hitting his left knee and the right ribs. -He had no head injury or loss of consciousness. -X-rays of the right ankle, left knee and right ribs were negative for fractures. <p>Review of an independent assessment for personal care services for Resident #7 dated 11/14/15 revealed:</p> <ul style="list-style-type: none"> -The assistive device of a rollator was checked as used. -Transfers required limited assistance, ambulation from room to room required set up/supervision and clearing pathways was total assistance. -As reported by a personal care aide and the RCC, the resident required assistance to transfer due to joint pain and impaired balance when standing. -As reported by a personal care aide and the RCC, the resident used his rollator when walking in the facility. <p>Observation on 11/9/15 at 11:50am of Resident #7 revealed:</p> <ul style="list-style-type: none"> -He was seated on a rollator in the vicinity of the medication room. -He remained seated on the rollator while he was pulled backwards by a staff member to the smoking area just outside the medication and common TV rooms. <p>Observation on 11/10/15 at 4:25pm of Resident #7 revealed:</p> <ul style="list-style-type: none"> -The resident was seated on a rollator in the outside smoking area near the medication room. -The resident was listening to a hand-held radio 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 133</p> <p>but was verbally responsive when spoken to.</p> <p>Interview on 11/10/15 at 4:25pm with Resident #7 revealed the brakes on his rollator "did not work" with no further elaboration.</p> <p>Observation on 11/10/15 at 4:25pm of the rollator of Resident #7 revealed:</p> <ul style="list-style-type: none"> -Squeeze handles attached to bicycle-type brake cables, further attached to metal brakes at the tires. -With active squeezing of the handles and with locking the handles, the metal brakes made slight contact with the tires but did not prevent the tires from rolling, the brakes easily scraping across the tires. -Releasing the squeeze handles moved the metal brakes away, permitting the free-rolling of the tires. <p>Interview on 11/11/15 at 10:45am with a Personal Care Aide revealed:</p> <ul style="list-style-type: none"> -She routinely cared for Resident #7. -The resident was "doing good" with his rollator, which was a new one, having had it for a few months. -The resident's rollator was "real sturdy." -If anything was found wrong with the rollator, staff would contact the Maintenance staff person and he would check it. -Some outside company could be called to fix rollators and wheelchairs and provide parts. -"His rollator is working fine." -His previous rollator "was broken" with the brakes unable to lock and one wheel hard to roll, like it was "jammed." -The outside company was called and the new and current rollator was obtained. -She could not remember when the new rollator arrived. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 134</p> <p>-Care staff do a shift-to-shift report and she did not remember anything being mentioned about falls with Resident #7.</p> <p>Interview on 11/11/15 at 11:15am with Resident #7 revealed: -The brakes on his rollator still did not work (he demonstrated this to the surveyor by squeezing the bicycle-type hand brakes and the wheels freely rolled). -He tried to get the attention of the Maintenance staff person but "he just kept on walking." -He had fallen in the past due to brakes not working on his rollator, but he could not remember when this occurred.</p> <p>Interview on 11/11/15 at 12:15pm with the Maintenance staff member revealed: -Maintenance of wheelchairs (W/Cs) and walkers was not his "primary responsibility," but sometimes he did get involved. -Facility leadership should use durable medical equipment (DME) suppliers outside of the facility to fix equipment they provide to residents. -If a piece of equipment immediately broke he would attempt to fix it, but he was down to a few W/C parts. -Resident #7 "went through five of those walkers this year," which were rebuilt then broken. -Resident #7 recently obtained a "brand new" walker about "two weeks ago." -Resident #7 had complained that his brakes needed adjustment but "nothing I can really do." -Resident #7's last walker had "wheel issues" and the current one might not be sized properly. -He adjusted W/C brakes and wheels as best as he could. -Staff would usually say something to him but "lots of things go on and I never hear about" them.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 135</p> <p>-The brake handles on the walker Resident #7 had previously (which had only been "a month or less") "broken off" and he could not fix the walker.</p> <p>-Resident #7 had been "yelling awhile [regarding the brakes on his rollator]" but the Maintenance staff person stated he could "look at them."</p> <p>Telephone interview with the guardian of Resident #7 on 11/12/15 at 12:30pm revealed:</p> <p>-She visited the resident every 3 months.</p> <p>-The resident had a history of falls and the facility contacted her when falls occurred.</p> <p>-The resident's psychotropic medications made him a fall risk.</p> <p>-The last time she visited the resident (date could not be recalled), the resident told her that his walker was "broken" (but she could not recall what "broken" referred to).</p> <p>-The resident was "very schizophrenic," "very sick man" and "does not comply with anything, does what he wants to do."</p> <p>Interview on 11/13/15 at 1:15pm with the Operations Manager revealed:</p> <p>-To adjust the brakes on the rollator of Resident #7 she would contact the DME supplier.</p> <p>Refer to additional interview on 11/13/15 at 1:15pm with the Operations Manager.</p> <p>2. Review of the most current FL-2 dated 9/17/15 for Resident #8 revealed:</p> <p>-Diagnoses which included amputated leg and amputated right hand digits #2 through #5.</p> <p>-Under the heading of Ambulation was checked "self-ambulatory."</p> <p>-Additional information hand-written was "pt [patient] has left leg amputation got missing 3 digits of right hand. Uses a wheelchair."</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 136</p> <p>Review of Resident #8's assessment and care plan dated 10/6/15 revealed: -Under the heading of Ambulation/Locomotion was checked "ambulatory w [with]/aide or device(s)" and "W/C [wheelchair]" was hand-written. -The activity of daily living (ADL) of ambulation/locomotion was given a performance code of zero (independent).</p> <p>Review of the Licensed Health Professional Support (LHPS) note for Resident #8 dated 10/22/15 revealed: -No checked pre-printed LHPS tasks (which included the task "ambulation using assistive devices"). -"He utilizes a wheelchair due to a left leg amputation." -"Resident observed self-propelling in a wheelchair. He is able to stand independently."</p> <p>Review of the most recent provider note for Resident #8 dated 11/3/15 revealed: -No recent falls. -ADLs was "need assistance." -"W/C" is circled on the provider form and written in under the heading of Gait.</p> <p>Observation on 11/9/15 at 4:15pm of Resident #8 revealed: -The resident standing in his room with use of metal crutches -An unoccupied lightweight W/C in his room. -The left armrest of the W/C had no padding, exposing the metal armrest frame. -The right armrest of the W/C had ripped foam padding, exposing the corners of the metal armrest frame. -The brake on the left wheel was present and operable.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 137</p> <ul style="list-style-type: none"> -The brake on the right wheel was missing. -When resting on the floor and moved side to side, the large wheels were noted as loose at their hubs on the frame, to the point of creating a wobble in the entire chair. <p>Interview on 11/9/15 at 4:15pm with Resident #8 revealed:</p> <ul style="list-style-type: none"> -He was not admitted with this or any W/C. -Unnamed staff had obtained the W/C from "the barn" (a storage shed) in the condition observed. -He denied having any falls related to use of the W/C since admission. -He was standing with the crutches to change his position as the W/C over time made him sore. <p>Interview on 11/11/15 at 11:25am with Resident #8 revealed:</p> <ul style="list-style-type: none"> -His W/C was "just about shot." -"I don't think they [staff] pay too much attention." -A man specializing in making prosthetic limbs saw the resident the previous week but they did not discuss getting him a new W/C. -He denied seeing physical therapy or occupational therapy recently about getting a W/C. -He would like padded armrests on the W/C as he used them for comfort when eating. -When he was sitting in the W/C, the large wheels had "a little play." <p>Interview on 11/11/15 at 12:15pm with the Maintenance staff member revealed:</p> <ul style="list-style-type: none"> -Resident #8 had a "good W/C" when he left the facility earlier this year. -Resident #8's current W/C was one "someone found in a room and gave to him." <p>Refer to additional interview on 11/13/15 at 1:15pm with the Operations Manager.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 138</p> <p>3. Review of the most current FL-2 dated 12/9/14 for Resident #20 revealed: -Diagnoses which included cerebral vascular accident (CVA) with left sided weakness, schizoaffective disorder, depression/anxiety and peripheral neuropathy. -Ambulation status is checked "non-ambulatory." -Medication orders which included divalproex sodium (an anti-seizure medication also used as a mood stabilizer), escitalopram (an anti-depressant), alprazolam (an anti-anxiety medication) as needed and quetiapine (an antipsychotic).</p> <p>Review of new medication orders for Resident #20 to the present revealed the additional medications of clonazepam (an anti-seizure medication used to treat panic attacks) and trazadone (an anti-depressant).</p> <p>Review of Resident #20's assessment and care plan dated 6/1/15 revealed: -The resident was ambulatory with an aide or device(s), with "W/C" written in. -The resident had limited range of motion in his upper extremities. -For the activities of daily living (ADL) of ambulation/locomotion and transferring, the performance code was a 3 (extensive assistance). -The assessment and care plan was signed by the Resident Care Coordinator (RCC) and the provider on 6/2/15.</p> <p>Review of a facsimile from a DME provider dated 9/15/14 revealed the provider was working on a "w/c [wheelchair]" repair request for the resident, but required a state DMA request for prior approval form be completed.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 139</p> <p>Review of a state DMA request for prior approval form for Resident #20 dated 9/17/14 revealed: -The resident required repairs to his W/C he received on 11/12/12. -The resident never had his W/C repaired. -"Patient can use W/C within the home on own safely." -The resident was confined to his W/C 8 hours a day. -The form had an illegible signature on the provider line and was dated 9/17/14. -There was no further documentation in the record regarding repairs to Resident #20's W/C.</p> <p>Review of a Licensed Health Professional Support (LHPS) note on Resident #21 dated 8/24/15 revealed: -A check mark next to the pre-printed LHPS task of "ambulation using assistive devices" and "transferring semi- (or) non-ambulatory residents." -"The care plan indicates that resident uses a wheelchair and requires transfer assistance and mobility assistance from staff." -Staff report that the resident tended to have others propel the device [wheelchair] for him and that it takes at least two people to transfer him. -The pre-printed LHPS personal care task provided of "wheelchair/transfers" with a check mark next to the pre-printed staff competency option of "see personnel files."</p> <p>Review of physician orders for Resident #20 dated 9/30/15 revealed renewal of an order with an original date of 10/29/13 for "fall safety-maintain safety precautions."</p> <p>Review of a provider note on Resident #20 dated 11/3/15 revealed:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 140</p> <p>-ADL option of "needs assistance" was circled on the form.</p> <p>-Left sided weakness was documented.</p> <p>Observation on 11/9/15 at 11:55am of Resident #20 revealed:</p> <p>-The resident seated in a wheelchair (W/C) at a table in the Dining Room.</p> <p>-The WC was dirty and the footrest bracket was covered in a black ash-like substance.</p> <p>Observation on 11/11/15 at 4:15pm of Resident #20 revealed:</p> <p>-The resident seated in a W/C in the smoking area outside the medication room.</p> <p>-The right brake slightly grabbed the wheel when engaged with wheel rolling.</p> <p>-The left brake did not grab the wheel at all when engaged with full wheel rolling.</p> <p>-The right armrest was ripped and missing padding, exposing the metal frame of the armrest.</p> <p>Observation on 11/16/15 at 1:45pm of Resident #20 revealed:</p> <p>-The resident was sitting in his W/C.</p> <p>-The right brake slightly grabbed the wheel when engaged with wheel rolling.</p> <p>-The left brake did not grab the wheel at all when engaged with full wheel rolling.</p> <p>-The right armrest was ripped and missing padding, exposing the metal frame of the armrest.</p> <p>-Black tape on the left footrest arm, holding the footrest to the wheelchair.</p> <p>-Tape residue on the W/C cushion.</p> <p>Interview with Resident #20 on 11/16/15 at 1:45pm revealed:</p> <p>-He used the W/C "every day."</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 141</p> <p>-The W/C cushion "made his butt sore." -He told the Resident Care Coordinator "four months ago" he needed a replacement.</p> <p>Refer to additional interview on 11/13/15 at 1:15pm with the Operations Manager.</p> <p>4. Review of the most current FL-2 dated 5/18/15 for Resident #19 revealed: -Diagnoses which included an above the knee amputation of the left leg and mental disorder. -Ambulation status was check as "non-ambulatory." -Medications included citalopram (an antidepressant).</p> <p>Review of the assessment and care plan for Resident #19 dated 6/2/15 revealed: -He was ambulatory with an aide or device(s), with "W/C [wheelchair]" written in. -He had limited strength in his upper extremities. -His activities of daily living (ADL) of ambulation/locomotion and transferring were given a performance code of 3 (extensive assistance). -The assessment and care plan were signed by the Resident Care Coordinator (RCC) and the provider on 6/2/15.</p> <p>Review of a provider note for Resident #19 dated 9/17/15 revealed: -The pre-printed ADL option of "needs assistance" was circled. -"W/C" was circled. -Additional diagnoses not on the FL-2 included chronic obstructive pulmonary disease, peripheral artery disease and chronic pain syndrome.</p> <p>Observation on 11/11/15 at 4:15pm of Resident #19 revealed:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 142</p> <ul style="list-style-type: none"> -The resident seated in a W/C in the smoking area outside the medication room, his right leg extended and supported and resting on the right footrest. -The left armrest vinyl covering was cracked. -The left brake did not grab the wheel when engaged was not completely aligned on the wheel. <p>Interview with Resident #19 on 11/11/15 at 4:15pm revealed no specific information regarding the left armrest and left brake on his W/C.</p> <p>Refer to additional interview on 11/13/15 at 1:15pm with the Operations Manager.</p> <p>Interview on 11/13/15 at 1:15pm with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -Third shift staff were expected to clean W/Cs, she brought this up "in the last several weeks" but would have to get with the third shift supervisor. -Repairs to resident equipment would be communicated by the third shift staff to the first shift via a verbal report. -A named outside DME supplier would be contacted for repairs but the Maintenance staff person could fix "simple things." <p>E. Review of Resident #21's most current FL-2 dated 8/10/15 revealed diagnoses which included schizophrenia, bipolar disorder, mental retardation and depression with anxiety.</p> <p>Observation on 11/12/15 at 2:15pm of Resident #21's room revealed:</p> <ul style="list-style-type: none"> -A stack of items approximately 3 feet high and 1 foot deep to the wall were noted immediately inside and to the right of the door frame. -A stack of items approximately 5 feet high were 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 143</p> <p>observed immediately to the left of the door frame, including a college dormitory-sized white refrigerator and box fan, which prevented the door from swinging all the way open.</p> <p>-A path, which exposed floor and measured from 1 to 2 feet wide, went from the door frame to a large green plastic container measuring approximately 2 feet wide by 3 feet long, the plastic container placed parallel to the bed (located against the wall where the window was located).</p> <p>-The large green plastic container prevented direct and clear egress from the bed to the door, with a path circumscribing the plastic container approximately 1 foot wide.</p> <p>-Piles of clothes, plastic bags and stuffed animals lined the paths in the room.</p> <p>-A path, which exposed floor and measured from 1 to 2 feet wide, turned right inside the door and went to the bathroom, with piles of items on either side of the path.</p> <p>-The door to the bathroom open, space surrounding the commode in the bathroom was taken by various items stacked approximately 5 to 6 feet up the walls.</p> <p>-Clothing was hanging across the top of the door.</p> <p>-A bureau approximately 5 to 6 feet long was pushed against a partially closed bi-fold closet door, with clothes pushing out of the drawers and with items (including a microwave) stacked on top of the bureau to the approximately 5 foot mark on the wall.</p> <p>Interview of Resident #21 on 11/12/15 at 2:15pm revealed the closet was "full of stuff."</p> <p>Review of a primary care provider note for Resident #21 dated 3/31/15 revealed: -"She does not keep room clean. Staff reports unable to walk through room. Staff states will not</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 144</p> <p>get up to take medications often." -Under the heading of activities of daily living (ADL) was circled the statement "needs assistance." -Under the heading of psych[iatric] the resident was documented as alert and oriented x3 (person, place and time) and "viewed room-unable to get in due to all her belongings." -The diagnosis of "hoarder." -Documentation that the resident refused medications for 8 days in the month of March and "recommend psych[iatric] eval[uation]."</p> <p>Review of a mental health provider note for Resident #21 dated 4/23/15 revealed: -A chief complaint of "anxiety and depressed mood continue to interfere w[with]/pt [patient] functioning." -Session content which included that due to the "pt hoarding" and multiple incidents of refusal to take medications as prescribed, the MD [physician] did not think the resident to be competent. -Session content with the resident reporting that "I clean my room every day."</p> <p>Review of Resident #21's assessment and care plan dated 5/12/15 and signed by the Resident Care Coordinator (RCC) and Nurse Practitioner provider revealed: -"Resident continues to do well" and "when upset she is easily directed." -History of mental illness was checked and that she was receiving mental health services. -The care plan listed in the section for Licensed Health Professional Staff (LHPS) and "other special care needs" pre-printed options which included "housekeeping," which was given a performance code of 4 (or totally dependent). -There was no further documentation specific to</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 338	<p>Continued From page 145</p> <p>housekeeping needs for this resident.</p> <p>Review of a mental health provider note for Resident #21 dated 5/14/15 revealed: -A chief complaint of "anxiety and depressed mood continue to interfere w [with]/pt [patient] functioning." -Session content included the resident was "out of sorts" and "not open to considering alternative perspectives or any considerations that did not agree w [with]/ her current assertions." -Session content included that the resident "left session without practicing healthy coping skills and apparently not happy w [with]/ this therapist."</p> <p>Review of an RN note who provided Licensed Health Professional Support (LHPS) for Resident #21 revealed: -No documentation of housekeeping concerns for notes dated 12/2/14, 3/2/15, 6/3/15 and 9/29/15. -The most recent LHPS note dated 9/29/15 listed finger stick blood sugars, ACE[wrap]/brace and therapy as her tasks. -The note dated 9/29/15 documented that the "resident was observed in her bed."</p> <p>Review of a staff progress note on Resident #21 dated 10/6/15 revealed: -The resident had "several refusals" of her morning (AM) medications. -She would not get up and would not allow staff into her room. -The MD and mental health would be notified.</p> <p>Review of the most recent notes by an Adult Nurse Practitioner (ANP) associated with the mental health provider for Resident #21 dated 10/13/15 revealed: -"Pt [patient] with chronic paranoid schizophrenia with mood lability and anxiety," "mild paranoia but</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 146</p> <p>overall she appears to be well-managed at this time" and "no changes in medications or therapies suggested."</p> <p>-For justification of the antipsychotic medication quetiapine the resident was noted having "chronic paranoid delusions" and gradual dose reduction (GDR) was contraindicated.</p> <p>Review of a Building Walk-through document, provided by the facility and dated 10/29/15 revealed the room occupied by Resident #21 was not in the column under the heading of "room #."</p> <p>Interview on 11/12/15 at 3:00pm with a Housekeeper revealed:</p> <p>-He was the "head" of cleaning rooms.</p> <p>-He would first "troubleshoot" rooms occupied by residents known to be "messy" or for those known to experience urine incontinence in bed, then proceed to cleaning other rooms.</p> <p>-He included Resident #21's room in a group of those occupying single, private rooms, which were "checked daily."</p> <p>-"I have difficulty" keeping Resident #21's room clean, which he described as "very cluttered" and the resident as not permitting housekeeping staff to enter the room.</p> <p>-Resident #21 "had lots of stuff."</p> <p>-Resident #21 would ask Housekeeping staff for paper towels, toilet tissue and "sticky pads" for "catching insects and rodents," but it had "been a while" since she had "mice" in her room.</p> <p>-The Operations Director and Vice President (VP) of Operations knew about Resident #21's room condition.</p> <p>-Persons had to "move side by side" to move through her room.</p> <p>-He was last permitted by the resident access to Resident #21's room in August to clean the filter on the window air conditioning unit.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 147</p> <p>Interview on 11/13/15 at 10:00am with another Housekeeper outside Resident #21's room revealed: -"She [Resident #21] won't let you in." -The resident just asked for paper towels and toilet paper. -As the Housekeeper was unlocking the door, she stated "I am covering my drink (placing her hand over her beverage can)" because "I don't want bugs in it."</p> <p>Interview on 11/13/15 at 10:20am with a Housekeeper revealed: -"If there were a fire staff might have to get [Resident #21] from a window." -Resident #21 had never allowed her into the room to clean.</p> <p>In addition the observations made on 11/12/15, further observation of Resident #21's room on 11/13/15 at 12:15pm revealed: -A path, which exposed floor and measured approximately from 1 to 2 feet wide, turned right inside the door and went to the bathroom, with piles of items on either side of the path. -The door to the bathroom open, space surrounding the commode in the bathroom was taken by various items stacked approximately 5 to 6 feet up the walls. -Numerous items were stacked on the vanity next to the sink, including dishes and a dish rack. -A bureau approximately 5 to 6 feet long was pushed against a partially closed bi-fold closet door, with clothing pushing out of the drawers and with items (including a microwave) stacked on top of the bureau to the approximately 5 foot mark on the wall.</p> <p>Interview on 12/13/15 at 12:40pm with the VP of</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 148</p> <p>Operations revealed the facility had tried "numerous times" to clean and organize Resident #21's room but the resident would not allow it.</p> <p>Telephone interview on 11/17/15 at 10:35am with Resident #21's Responsible Person was attempted but unsuccessful.</p> <p>Telephone interview on 11/17/15 at 10:45am with a Nurse Practitioner from Resident #21's primary care clinic was attempted but unsuccessful.</p> <p>Telephone interview on 11/17/15 at 10:45am with an administrative office employee of the mental health provider for Resident #21 revealed: -The resident was last seen by the licensed therapist on 5/14/15 and was no longer receiving therapy services. -The resident was seen on 8/18/15, 9/16/15 and 10/13/15 by the nurse practitioner providing review of the resident's psychiatric medication management.</p> <p>Telephone interview on 11/17/15 at 10:53am with RN who performs LHPS services revealed: -She had been assigned to the facility for the previous three months and was still "trying to establish rapport" with Resident #21. -She referred to the resident as "the hoarder holed in her room." -The resident was a psychiatric patient who was "secretive" and she limited her interactions with her. -As the resident had a mental health history, she did not pressure her for anything. -She has had no conversation with staff regarding Resident #21, but staff were appropriate with the resident. -"These [mental health residents] are my normal clientele" and "you can only fight them on so</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 149</p> <p>many things."</p> <p>-A "narrow pathway" was observed in the resident's room and the path was clear from the door to the bed.</p> <p>-The facility has probably "tried things historically."</p> <p>-She only reviewed care for residents based on LHPS tasks.</p> <p>Interview with the Nurse Practitioner (NP), associated with the mental health provider for Resident #21, on 11/17/15 at 2:13pm revealed:</p> <p>-He was an adult NP who was "working on" his psychiatric mental health NP credentials.</p> <p>-He was providing medication review services only and that another provider performed counseling services for residents.</p> <p>-He came to the facility each week.</p> <p>-Reviews of psychiatric medications were at least monthly but could be every two weeks if necessary.</p> <p>-He expected staff to call the mental health provider triage line if things changed for residents.</p> <p>-The mental health provider created no specific mental health care plans for their assigned residents. "Real bad" residents were seen by another named mental health provider and he saw "stable" residents.</p> <p>-Resident #21 did "very well" and was one of the higher functioning residents at the facility.</p> <p>-Resident #21 exhibited some "paranoia," had focused the last previous months on perceived wrongs and was a bit suggestible.</p> <p>-Resident #21 "has hoarding qualities," liked to be in control and got "very touchy" if anyone tried to touch her stuff.</p> <p>-Staff had shown "concern" with hoarding tendencies.</p> <p>-A few weeks prior, an exterminator was in the</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 150</p> <p>facility spraying and he did not go into Resident #21's room.</p> <p>-Resident #21's hoarding tendencies had been going on for "many, many years," "medicine will not fix" the tendencies and you have to "try to work around it."</p> <p>"Hoarding is detrimental when someone is so afraid someone will clean their room they will not leave their room."</p> <p>-He would also defer to the health care provider as their might be some health concerns, "like food" is in the room.</p> <p>-There used to be a facility requirement that residents could "only have so much" in possessions.</p> <p>"I think the facility needs to address the hoarding issue."</p> <p>-He had never seen her room as he interviewed residents in a separate room.</p> <p>-He reviewed every note with the licensed therapist in the mental health practice.</p> <p>"I would want to know from staff if [resident's] hoarding resulted in [pest] infestation."</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed:</p> <p>-Resident #21 "hoards stuff" and would not let the RCC into her room.</p> <p>-Resident #21 would tell staff if her window blinds were messed up, she was told staff would have to enter her room which they did to fix the blinds.</p> <p>-The resident was told to move stuff from behind her door, but she did not know if it got moved as the resident would not allow staff to enter her room.</p> <p>-The resident changed her own bed linens, emptied her own trash and "won't let them [facility staff] in to do nothing."</p> <p>-Staff did not tell her that Resident #21 had cockroaches and that the pest control technician</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 151</p> <p>had "attempted" to spray for them, but she was not sure if the technician got into the resident's room.</p> <p>-Resident #21 refused to talk to the mental health provider and she was not sure why.</p> <p>-She had told the mental health provider that Resident #21 was a hoarder and that the resident was "a challenge."</p> <p>Telephone interview with the licensed therapist from Resident #21's mental health provider on 11/18/15 at 12:30pm revealed:</p> <p>-Counseling per se is something the resident was unable to effectively use.</p> <p>-The resident was not "moving forward" with meeting her goals, was "not dealing with reality," got angry with the therapist and refused to see her.</p> <p>-The resident had no insight, had cognitive limitations and it was difficult for her to receive input.</p> <p>-She was aware of the issue with the resident's room being full of clutter and junk, had personally never seen her room and never had heard staff use the word "hoarding."</p> <p>-If someone used the word "hoarding" to her as a therapist it would "set off alarms."</p> <p>-Hoarding is more "self-abuse" and "self-neglect."</p> <p>-With the resources the facility had they were doing "the best they could."</p> <p>-Due to the resident's lack of insight and hostility, the facility did not think it worthwhile to send the resident to the hospital, which is what should probably happen.</p> <p>-If a Fire Marshall were to inspect the room in uniform and looking "official," she might receive information regarding the clutter in the room and the facility would be empowered to do something about it.</p> <p>-Management of the resident's clutter might</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 152</p> <p>include installation of shelving in her closet and on the walls, removing piles of items from behind her door, making sure nothing touches her ceiling and following through with any Fire Marshall recommendations.</p> <p>-It was emotionally distressing for a hoarder to have other people touch her stuff.</p> <p>F. Review of Resident #3's current FL2 dated 09/01/15 revealed: -Diagnoses of mild mental retardation, Turner's syndrome, seizure disorder, mood disorder, left sided hemiparesis, partial blindness.</p> <p>Review of Resident #3's record revealed the resident was deemed incompetent and had a court appointed guardian. The resident was not allowed to make decisions without the guardian's knowledge.</p> <p>Review of Resident #3's Resident Register revealed an admission date of 09/08/14.</p> <p>Review of Resident #3's Care Plan signed by the physician on 09/01/15 revealed: -The document was prepared by the Resident Care Coordinator (RCC). -The resident was currently receiving medication for mental illness/behaviors. The resident had a history of mental illness. -The resident was currently receiving mental health services. -The RCC documented the resident had to be redirected at times because tends to become "attached" to staff, wanted constant undivided attention.</p> <p>Review of Resident #3's progress notes revealed: -01/02/15 (second shift, no time) Resident #3</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 153</p> <p>threw wet floor sign at another resident and staff. -02/05/15 (first shift, no time) Resident #3 was in another female resident's room going through her things. -02/16/15 (first shift, no time) Resident #3 was caught by staff going through her roommates belongings, again. -02/20/15 (first shift, no time) Resident #3 was involved in a physical altercation with a male resident due to stealing. -03/10/15 second shift (no time) Resident #3 was found in several residents rooms going through their belongings. -03/14/15 first shift (no time) Resident #3 was found going through another female resident belongings. -03/26/15 first shift (no time) Resident #3 was caught coming out of residents' rooms who were out of the facility. -03/30/15 at 7:00pm Resident #3 told staff that a male resident made her perform sexual favors. -03/31/15 second shift (no time) Resident #3 was observed "hanging out w/ Rt in her room whom she accused the previous evening of rape." -04/22/15 at 7:00pm It was reported and Resident #3 admitted she went into a male resident room and stole his body spray. -05/09/15 at 10:45am Resident #3 had stolen item from her roommate. -05/11/15 (no time) Resident #3 continues to go into other residents rooms and take their things. -06/06/15 First shift (no time) staff caught Resident #3 several times in other residents' rooms. -07/01/15 at 2:19 (no document AM/PM) Resident wouldn't stay off the men's hall tonight. She was going in and out of residents rooms. -07/25/15 (no time) Resident was asked about a radio observed in her room that belonged to a male resident.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 154</p> <p>-08/03/15 at 5:10am, third shift staff reported Resident #3 was hit in the face and cursed by a male resident.</p> <p>-08/28/15 second shift (no time) Resident involved in a physical altercation with a male resident.</p> <p>-10/14/15 at 7:30am Resident #3 walked off facility property, staff picked the resident up and brought her back.</p> <p>-10/24/15 (first shift, no time) Resident #3 was caught going into other residents rooms, stealing their "belongs."</p> <p>-10/24/15 at 12:30pm Resident #3 came in the dining room with clothes hanger around her neck, ACTT called.</p> <p>-10/26/15 at 6:10am Resident #3 left the facility "grounds" after being redirected. The resident cursed and made inappropriate sexual remarks to staff.</p> <p>Review of Resident #3's record failed to reveal a plan of safety to ensure safe sexual practices, and ensure sexual encounters were consensual with the resident and guardian.</p> <p>Interview on 11/09/15 at 3:50pm with Resident #5 revealed:</p> <p>-Resident #3 had problems and would steal and runaway at night.</p> <p>-The resident also had a problem with sleeping with all the guys and was trying to sleep with the male cook.</p> <p>Interview on 11/12/15 at 10:40pm with a second shift Personal Care Aide (PCA) revealed:</p> <p>-She was unaware that Resident #3 was promiscuous.</p> <p>-Resident #3 walks off from the facility, but does not date men.</p> <p>-The resident entered rooms to steal not to be</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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	<p>Continued From page 155</p> <p>with men.</p> <p>Interview on 11/12/15 at 10:55pm with the third shift Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> -On the third shift rounds were done every two hours to determine residents whereabouts. -If residents were observed in another resident's room they asked to leave and return to their own room. -"Resident #3 gets into bed with men all the time." -The resident was mostly found in one particular male resident's room. -She told the resident, "you can't be there," the resident gets upset and will try to walk off from the facility. -Sometimes she had to take Resident #3 by the hand and pull the resident out the male resident's room. -When she checked two hours later Resident #3 had returned back to the male resident's room. -She had never been instructed to monitor Resident #3 more than the facility's protocol every 2 hours, unless management had put the resident on 15 minute checks. -The resident was not on 15 minute checks every day. <p>Interview on 11/12/15 at 3:38pm with the housekeeper revealed:</p> <ul style="list-style-type: none"> -He worked for the facility for 18 months. -Two months ago he walked in on a sexual encounter with Resident #3 and another resident. -After knocking on the door no one answered when he opened the door it was Resident #3 with another male resident, not her current supposed boyfriend. -Resident #3 does different things (sexually) for a dollar. -He told the Medication Aide, and by the time he got back they were gone. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 156</p> <p>-It was the facility's policy that residents are not supposed to sleep together, and not to be in other resident's bed after hours.</p> <p>-Resident #3 was not allowed the 300/400 halls because she sneaks into male residents rooms.</p> <p>Interview on 11/13/15 at 12:10am with the third shift Medication Aide (MA) revealed:</p> <p>-When staff did rounds Resident #3 was found in male resident rooms.</p> <p>-Staff have to redirect and tell the resident to leave.</p> <p>-The resident usually left, but when rooms were checked 2 hours later Resident #3 had sneaked back in the room.</p> <p>-Staff put the incident in shift report to inform management.</p> <p>Interview on 11/16/17 at 3:58pm with Resident #3's guardian revealed:</p> <p>-She visited the resident quarterly.</p> <p>-She was aware that Resident #3 was promiscuous, but thought the residents' other behaviors (walking off from the facility) were worse.</p> <p>-The facility monitored the resident and redirected her when the resident was identified in male residents' bedrooms.</p> <p>Interview on 11/17/15 at 10:11am with the Operations Manager revealed:</p> <p>-She was unaware that Resident #3 was someone that was sexually active at all.</p> <p>-From time to time staff will comment they walked in on some residents engaged in sexual activity, but they had never mentioned Resident #3.</p> <p>-She thought maybe Resident #3 was going in rooms to steal things, not to have sex.</p> <p>-No one had told her Resident #3 was going in to rooms to have sex.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 157</p> <p>-Second shift staff may have been directly communicating with the guardian, but they did not tell her that Resident #3 was going into residents' rooms to have sex.</p> <p>-Said if facility staff were not able to correct (redirecting by communication) Resident #3's patterns of behavior, then she may have to discharge the resident.</p> <p>Interview on 11/17/15 at 2:23pm with the Nurse Practitioner revealed: -He usually did not see Resident #3 when in the facility, his co-worker was the last to see Resident #3.</p> <p>Interview on 11/17/15 at 3:50pm with the mental health Nurse Practitioner revealed: -He started seeing Resident #3 in September 2015. -Resident #3 was sexually active. -He was aware the resident was sneaking into all the male resident rooms. -He had talked with the RCC how to handle Resident #3 sexual behaviors, because in his opinion the resident did not make good decisions. -Staff watching the resident to redirect her was the best way. -Resident #3 was also someone who sat-back and agitated other people and caused others to get into it. -He saw Resident #3 last week, and ordered a medication to help with behaviors and to decrease sexual urges. -The resident refused the medication so he stopped the order.</p> <p>Interview on 11/17/15 at 5:19pm with the second shift Medication Aide revealed: -When Resident #3 does not get her way, she gets upset and walks off.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 158</p> <ul style="list-style-type: none"> -Resident #3 had been identified as being promiscuous. -The resident was often caught in male residents' rooms. -She had been told Resident #3 sleeps with men for money. -She basically evaluated to see the rooms the resident was going in and out of, so they can redirect. -Rounds were done every 2 hours, so the resident was usually not observed until staff did rounds. -The resident has previously been put on 15 minute checks to keep the resident out of male resident rooms. -The 15 minute check list had reason (walk off, going in rooms, etc.) documented on the first page. -Resident #3 had a guardian, but the guardian hardly visited the resident. -The guardian gave the impression she did not care about the resident, and the resident was "our" problem. -The guardian hardly ever visited the resident, and will ask other guardian's from her agency to visit the resident for her. <p>G. Review of Resident #6's current FL2 dated 02/27/15 revealed:</p> <ul style="list-style-type: none"> -Diagnoses of episodic mood disorder, unspecified, post-traumatic stress disorder, personality disorder, seizures, and insulin dependency. <p>Review of Resident #6's record revealed the resident was deemed incompetent and had a court appointed guardian. The resident was not allowed to make decisions without the guardian's knowledge.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 159</p> <p>Review of Resident #6's Resident Register revealed the resident's admission date to the facility was 01/28/15.</p> <p>Review of Resident #6's current Care Plan signed by the physician on 03/03/15 revealed:</p> <ul style="list-style-type: none"> -The document was prepared by the Resident Care Coordinator. -The resident had a history of mental illness. -The resident currently received mental health services. - The resident was not allowed to leave the facility without guardian prior approval and staff supervision. -The resident required supervision with meals. -The resident was independent in all ADLs. <p>Review of Resident #6's record revealed the resident had a pregnancy test on each of the following dates, the results of each test was negative as follows:</p> <ul style="list-style-type: none"> -04/04/15 resident had a pregnancy test, result negative -04/06/15 resident had a pregnancy test, result negative -05/06/15 resident had a pregnancy test, result negative -05/15/15 resident had a pregnancy test, result negative. -07/24/15 resident had a pregnancy test, result negative. -07/27/15 resident had a pregnancy test, result negative. -08/12/15 resident had a pregnancy test, result negative. -04/24/15 resident requested sexually transmitted disease (STD) test, negative. <p>Based on Resident #6's multiple request for pregnancy test it was evident the resident was</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 160</p> <p>sexually active. Review of Resident #6's record failed to reveal a plan of safety to ensure the resident practiced safe sex, and to further ensure sexual encounters were consensual with the resident and guardian.</p> <p>Observation on 11/17/15 from 3:09pm to 3:45pm of Resident #6 and #8 revealed: -At 3:09 pm Resident #6 was in her room with the door closed. -Knock on the door, opening the door revealed Resident #6 was in bed, and Resident #8 was on crutches standing beside the bed. -At 3:22pm Resident #6 and #8 were outside sitting and holding hands. -At 3:43pm Both residents were observed in Resident #8's room with the door open. -Both residents were sitting on Resident #8's bed with their backs against the wall. -Resident #6 was leaned over on Resident #8's right arm and shoulder. -Resident #6 was using her fingers rubbing in a circular motions on Resident #8's chest.</p> <p>Interview on 11/11/15 at 3:34pm with Resident #6 revealed: -She did not have boyfriend and she was not sexually active. -She took a pregnancy test because they (facility) tell her to take one. -She was on birth control and it made her feel full, and she does not have a period. -She thought that she was pregnant. -Staff sometimes knocked on her door to inform it was time for meals.</p> <p>Interview on 11/12/15 at 3:38pm with the housekeeper revealed: -He had worked at the facility for at least 18 months.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 161</p> <ul style="list-style-type: none"> -He observed residents in sexual relationships. -He had walked in on residents in the common bathroom. -He leaves to go to tell staff, and by the time he returned the residents were dressed and gone. -He was aware that Resident #6's current boyfriend was Resident #8. -The resident was previously with Residents #25, and 2 other residents, one of which was no longer at the facility. -Resident #6 switched back and forth between the 3 men. -The resident will break-up with one because he was not paying her any attention, or they (male resident) will break-up with her because they had gotten what they wanted (sex) and did not want her anymore. <p>Interview on 11/17/15 at 10:23am with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -To her knowledge Resident #6 was not someone who bounced around from room to room with men. -Staff have not made her aware they were seeing Resident #6 in rooms with men. -She was unaware how many pregnancy tests Resident #6 had done. -The resident had to have asked the doctor or Nurse Practitioner to order the pregnancy test. -Results were sent to the facility, but she was unaware of the test or the results. <p>Interview on 11/17/15 at 2:10pm with Resident #6's guardian revealed:</p> <ul style="list-style-type: none"> -Resident #6 was a "promiscuous young lady." -He was not sure the resident was trying to get pregnant but she "had a hard time allowing her birth control devices to stay in place." -Resident #6 having sex was a concern for him. -He had talked with the Operations Manager 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 162</p> <p>about the resident having sex, and OM was supposed to talk to the resident.</p> <p>-In March 2015 the resident got an implant (birth control device) in her arm, and she continually complained that she wanted it out, even irritating her arm.</p> <p>-He was not sure the last time Resident #6 was tested for a Sexually Transmitted Disease, but "it's probably a good idea to have her tested."</p> <p>-Resident #6 was not a truthful person, usually 90% of what the resident said was not the truth.</p> <p>-The resident "used men and spit them out, and moved on to the next man."</p> <p>-Resident #6 had behavioral issues, the facility usually called crisis intervention.</p> <p>-Crisis intervention was called 4-5 times last week for Resident #6 mental behaviors with aggression and anxiety.</p> <p>Interview on 11/17/15 at 5:10pm with the second shift Medication Aide revealed:</p> <p>-Resident #6 was sometimes a "trouble maker."</p> <p>-Annoying people, then "standing off watching to see how others exploded."</p> <p>-The resident told her boyfriend (resident) that two male staff were interested in her, and the boyfriend got upset with staff.</p> <p>-Resident #6 had been caught in intimate relationships with several male residents.</p> <p>-When staff observed the interaction, they would tell management.</p> <p>Interview on 11/18/15 at 12:45pm with a representative of mental health revealed:</p> <p>-Resident #6 was very promiscuous, and jumped around from boyfriend to boyfriend.</p> <p>-He thought residents at the facility were not monitored and often residents could have up to 10 partners before staff realized the residents were sexually active.</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 163</p> <p>-He was unaware if Resident #6 was monitored specifically for sexual activity.</p> <p>-Resident #6 usually kept one boyfriend for about one week and then moved to the next one.</p> <p>-He usually talked with the facility about Resident #6's aggression and behaviors, there had been no talk about the resident's promiscuous behaviors.</p> <p>Interview on 11/17/15 at 2:11pm with the Nurse Practitioner revealed:</p> <p>-He was in the facility once every month.</p> <p>-He had a co-worker that came once monthly also, alternating with his visits.</p> <p>-"Resident #6 was a bad Type 1 diabetic that was very non-compliant and hard to deal with."</p> <p>-He was not aware that Resident #6 was promiscuous.</p> <p>-He knew the resident had a boyfriend, but was unaware the resident continually changed men.</p> <p>Interviews on 11/12/15 at 10:40pm with a second shift Personal Care Aide (PCA) revealed:</p> <p>-Resident #6 had a boyfriend, but would break-up one day, then back together the next day.</p> <p>-She was unaware if the residents had been engaged in promiscuous activity on the second shift.</p> <p>-She heard that residents were promiscuous on the 3rd shift.</p> <p>-She was unable to recall any specific names.</p> <p>Confidential interview with a resident revealed:</p> <p>-He lived at the facility over 10 years.</p> <p>-Resident #6 had been with various men, (three he could recall), but not him.</p> <p>H. [Refer to tag 911 G.S. 131D-21 (1) Resident Rights (Type A2 Violation)] Based on observation, interview and record review, the</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 164</p> <p>facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy by routinely crushing medications for all residents when not indicated in all residents' individualized plan of care; by failing to consider the individual needs and privacy of each resident during medication administration by requiring residents to line up in the hallway to receive medications; by failing to administer injectable medications discreetly and in private; failing to respect and ensure the dignity of residents by dressing residents in ill-fitting and tattered clothing that did not belong to the residents; and by failing to provide a complete set of flatware to each resident at meal times.</p> <p>_____</p> <p>A plan of protection was submitted by the facility on 11/13/15, 11/18/15 with an addendum submitted on 11/30/15 that included:</p> <ul style="list-style-type: none"> -RCC contacted medical supply company for repairs to certain ambulatory devices which had minor repair needs. Most devices were already repaired in house today and contracted providers aware going to determine which residents were Medicaid/Medicare eligible for new devices. -VP of Operations contacted sister/guardian of resident who was reported hoarding behaviors to discuss options for this resident. Contact will be made with the resident's mental health counselor. Resident's MCO will also be contacted for additional assistance on best way to work with this individual. Resident's sister/guardian has been made aware of the current situation with resident. -Facility staff will begin process of deep cleaning resident's room 11/23/15. -Management will continue to encourage resident to understand how hoarding issues are detrimental. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 338	<p>Continued From page 165</p> <p>Addendum: -Facility will re-educate residents regarding resident rights and specifically resources available (access to counselors at local health department, condoms, etc.) for safe sex. -Facility will also include discussion that any sex must be consensual or else it would be considered assault. -Facility will report and assaults per state regulations.</p> <p>_____</p> <p>The violations of resident rights identified resulted in serious abuse, neglect and exploitation as evidenced by the failure of the facility to protect residents from resident-to-resident abuse (physical assaults), the admission and failure to discharge residents with aggressive and dangerous behaviors; implementing a work program that was used as a tool for discipline and coercion and not given fair or equitable compensation for work completed that benefited the facility; failing to properly maintain and repair durable medical equipment and placing residents at risk of injury; failing to manage Resident #21's hoarding behavior which resulted in a safety hazard and cockroach infestation in the resident's room; and failing to ensure residents #3 and #6 were engaged in safe sex practices that were consensual.</p> <p>DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2015.</p>	D 338		
D 344	<p>10A NCAC 13F .1002(a) Medication Orders</p> <p>10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 344	<p>Continued From page 166</p> <p>the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:</p> <p>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;</p> <p>(2) if orders are not clear or complete; or</p> <p>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.</p> <p>The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure contact with the resident's physician for clarification of medication orders for 2 of 9 residents sampled; one resident with an order for clonazepam not included on readmission from a local hospital (Resident #13); and changes in dosage for clozapine (Resident #25) and sliding scale insulin parameters from a hospital discharge summary for one resident (Resident #25).</p> <p>The findings are:</p> <p>A. Review of Resident #13's previous FL-2 dated 4/15/15 revealed: -Diagnoses included schizophrenia (continuous moderate); other specified personality disorder (mixed); and sedative, hypnotic, or anxiolytic disorder in remission in a controlled setting. -A physician's order for clonazepam 0.5 mg one tablet 2 times a day. (Clonazepam is used to treat various seizure disorders, panic disorders, and various mental disorders.)</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 344	<p>Continued From page 167</p> <p>Review of Resident #13's current FL-2 dated 7/17/15 from a psychiatric hospitalization from 7/11/15 to 7/17/15 revealed diagnoses included schizophrenia, and depressive disorder.</p> <p>Review of Resident #13's record revealed no discharge summary from the hospitalization from 7/11/15 to 7/17/15.</p> <p>Continued review of Resident #13's current FL-2 dated 7/17/15 revealed no physician's order for clonazepam.</p> <p>Review of Resident #13's record revealed: -No documentation for clarification of medication orders from 7/17/15 to 7/20/15. -A physician's order, ordered by the facility's psychiatric team, dated 7/20/15 prescribing clonazepam 0.5mg 2 times a day.</p> <p>Review of Resident #13's electronic Medication Administration Record (eMAR) for for July 2015 revealed: -Clonazepam 0.5mg was listed on the eMAR and scheduled for administration at 8:00am and 8:00pm. -Clonazepam 0.5mg was documented administered at 8:00am and 8:00pm daily on 7/1/15, 7/2/15, refused at 8:00am on 7/3/15 and administered at 8:00pm on 7/3/15, 7/4/15. -Clonazepam 0.5mg was documented as not administered with reason of "hospital" for 7/5/15 to 7/17 (8:00am) and marked as discontinued. -Clonazepam 0.5mg was documented administered 7/20/15 at 8:00pm. -Clonazepam 0.5mg was documented administered at 8:00am and 8:00pm from 7/21/15 to 7/31/15, except "leave of absence" at 8:00am on 7/23/15.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 168</p> <p>Interview on 11/18/15 at 12:40pm with a representative for the mental health team that provided service for the facility revealed:</p> <ul style="list-style-type: none"> -The mental health team had representatives at the facility 3 to 4 days each week. -The mental health team is available 24 hours a day, 7 days a week for the facility with either the team assigned to the facility or on call team members. -The facility could clarify orders when received by contacting the mental health provider team. <p>Interviews on 11/18/15 at 4:00pm and 11/19/15 at 11:00am with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -Resident #13 was sent out to a local hospital for observation on 7/5/15. -Resident #13 was transferred from the a local hospital to a second local hospital and was discharged back to the facility on 7/17/15. -The facility and the mental health team had requested a discharge summary, for the hospital visit ending 7/17/15, back in July 2015, but still had not received the discharge summary as of 11/19/15. -Medication Aide staff routinely compared the list of medications provided at discharge to the residents' eMAR prior to hospitalization and were responsible to clarify any discrepancy in medications. -She was not sure why medication aide staff did not clarify clonazepam 0.5mg on 7/17/15. -The resident had been discharged from the facility in October 2015. <p>Interview with the Resident Care Coordinator (RCC) on 11/18/15 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -The Supervisor/Medication Aide (MA) who was working when a resident returned from the hospital and received the orders was responsible to verify the medication orders against 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D 344	<p>Continued From page 169</p> <p>medications in the eMAR system and clarify any medications that did not match.</p> <p>-Orders that did not match the eMAR and current orders should be clarified with the prescriber.</p> <p>-The RCC was unaware the hospital discharge medication orders for Resident #17 did not include clonazepam 0.5mg.</p> <p>-She did not recall personally reviewing the 7/17/15 hospital FL-2 medications for Resident #13.</p> <p>-She was not sure why the order for clonazepam 0.5mg had not been clarified since the resident was on the medication when hospitalized and not on the medication when discharged from the hospital.</p> <p>Interview with the Mental Health Nurse Practitioner on 11/19/15 at 11:30am revealed:</p> <p>-She was not aware Resident #13 did not have clonazepam 0.5 mg from 7/17/15 to 7/20/15.</p> <p>-The provider practice had a practitioner on call that could have been reached for clarification of resident's orders.</p> <p>-She had not seen a discharge summary for the resident from the hospitalization from 7/7/15 to 7/17/15. (She was not sure why the resident's record did not include a copy of the hospital discharge summary for review.)</p> <p>-She stated she did not routinely stop a resident's clonazepam without tapering off the medication because of the possibility of adverse side effects (like seizures).</p> <p>-It appeared clonazepam 0.5 mg two times a day was restarted when the psychiatric team saw the resident at the facility on 7/20/15.</p> <p>-The resident had been discharged from the facility in October 2015.</p> <p>Resident #13 was discharged from the facility 10/14/15 and was not available for interview.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 170</p> <p>B. Review of Resident #25's current FL-2 dated 10/15/15 revealed: -Diagnoses included Diabetes Mellitus II, Schizophrenia and substance abuse. -A black hexagon alert sticker in the #18 Medications section contained documentation of "Use discharge instructions on the day of discharge as orders and for medications."</p> <p>1. Review of the hospital discharge summary dated 10/14/15 revealed a medication order for clozapine 100mg (an antipsychotic) three times daily.</p> <p>Review of the previous 6 month Physician's Orders dated 9/30/15 revealed the order for clozapine was 200mg 3 times daily.</p> <p>Review of Resident #25's record revealed the clozapine was previously ordered July 7, 2015 for 200mg tablets 3 times daily by the Mental Health Nurse Practitioner.</p> <p>Review of the resident's electronic Medication Administration Record (eMAR) for October 1-14, 2015 revealed: -Clozapine 200mg 3 times daily was transcribed with scheduled times of 8:00am, 2:00pm and 8:00pm daily and documented as administered. -There was no other transcription entry for Clozapine.</p> <p>Review of the resident's eMAR post hospital discharge for October 15-31, 2015 revealed: -Clozapine 100mg, take two tablets three times daily was transcribed with scheduled times of 8:00am, 2:00pm and 8:00pm daily and documented as administered. -There was no other transcription entry for</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 171</p> <p>Clozapine.</p> <p>Review of Resident #25's eMAR for November 1-18, 2015 revealed: -Clozapine 200mg 3 times daily was transcribed with scheduled times of 8:00am, 2:00pm and 8:00pm daily and documented as administered. -There was no transcription entry for Clozapine.</p> <p>Interview with Resident #25 on 11/19/15 at 10:00am revealed: -He relied on the facility to administer his medications according to doctor's orders. -He did not believe his medication changed after he came back from the hospital.</p> <p>Interview with the facility's pharmacy on 11/19/15 at 9:00am revealed: -The last hand written order for clozapine was 7/7/15 for 12 months with laboratory tests every 28 days. -The last two refills were on 10/7/15 and 11/5/15, each for 168 tablets of clozapine 100mg with instruction to administer two tablets three times daily (200 mg total 3 times daily). -The pharmacy did not have a copy of the resident's hospital discharge summary of 10/14/15 on file, nor were they aware there was a new order for clozapine. -The pharmacy reported they usually received the FL-2s and discharge summary, or a verification from the facility after a resident's readmission. -The pharmacy was unaware the resident was in the hospital in October 2015. -The pharmacy would expect to discontinue all medications while the resident was in the hospital and re-enter the new medications from the FL-2 or discharge summary when the resident came back to the facility.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 172</p> <p>Observation of Resident #25's medication available for administration on 11/18/15 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -A partial bubble card of clozapine 100mg tablets dispensed on 11/5/15, packaged two tablets to the bubble with 24 tablets remaining with label instructions to administer two tablets three times daily. -A second full bubble card of clozapine 100mg tablets dispensed on 11/5/15 which contained 128 tablets packaged two tablets per bubble with label instructions to administer two tablets three times daily. <p>Interview with a second shift Medication Aide (MA) on 11/18/15 at 3:45pm revealed:</p> <ul style="list-style-type: none"> -The two cards of clozapine was all she was aware of for Resident #25. -She had administered two tablets in the evening to Resident #25 for several months. -She was not aware of any other orders for clozapine for Resident #25. -The MA further stated usually the MA receiving new orders, including FL-2s and discharge summaries, would enter the orders into the eMAR and fax the orders to the pharmacy. -The MA are supposed to initial the orders when they are entered and then place in the resident's record. <p>Interview with the Resident Care Coordinator (RCC) on 11/18/15 at 4:40pm and 11/19/15 at 1:30pm revealed:</p> <ul style="list-style-type: none"> -She was unaware the hospital discharge medication orders for Resident #25 were not the same as what was currently on the eMAR. -She did not recall personally reviewing the 10/14/15 hospital discharge summary for Resident #25. -Usually the Supervisor/MA who received the 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 173</p> <p>orders would enter them into the eMAR system, initial and send to the pharmacy.</p> <p>-The RCC and the MA confirmed there were no staff initials on the hospital discharge summary faxed to the facility.</p> <p>-Usually the FL-2s are clarified with the primary care doctor and mental health provider; "personally I would call the MD."</p> <p>Interview with the Mental Health Nurse Practitioner on 11/19/15 at 11:30am revealed:</p> <p>-She did not recall reviewing the hospital discharge summary and not aware the dosage of clozapine had been changed.</p> <p>-She did not want the dosage changed from the 200mg three times daily as it was working well for him.</p> <p>-She did not recall receiving a facility medication verification form or had contact with the pharmacy.</p> <p>-The last date of of changes in the clozapine dosage was made was in July 2015.</p> <p>-She expected the resident to receive his laboratory tests monthly and the facility faxed the results to her and the pharmacy.</p> <p>-She did not believe there had been any lapses in getting the lab work done timely.</p> <p>2. Continued review of Resident #25's hospital discharge summary and FL-2 dated 10/14/15 revealed a medication order for the administration of Humalog Sliding Scale insulin coverage before meals and at bedtime with the following parameters: "Blood Sugar 151-200 = 2 units; Blood Sugar 201-250 = 4 units; Blood Sugar 251-300 = 6 units; Blood Sugar 301-350 = 8 units; Blood Sugar 351-400 = 10 units; and Blood Sugar 401 or greater = 12 units."</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 174</p> <p>Review of the 6 month Physician Order renewal sheet signed on 9/30/15 revealed the following Humalog Sliding Scale Insulin (SSI) order: -Fingerstick Blood Sugars are before meals and at bedtime. -Administer SSI with the following parameters: "200-300 = 5 units; 301-350 = 7 units; 351-400 = 9 units; 401-450 = 11 units; 451-500 = 13 units and if greater than 500, Call MD."</p> <p>Review of the resident's October 1-14, 2015, eMAR revealed: -SSI coverage was scheduled at 7:30am, 12:30pm, 17:30pm and 20:00pm daily. -The SSI coverage order was transcribed according to the 9/30/15 Physician's Orders and was documented as administered with the same parameters. -The blood sugar range was 102 to 373.</p> <p>Review of the resident's October 15-31 2015, eMar revealed: -SSI coverage was scheduled at 7:30am, 12:30pm, 17:30pm and 20:00pm daily. -The SSI coverage order was transcribed according to the 9/30/15 Physician's Orders and was documented as administered with the same parameters. -The SSI parameters of the hospital discharge summary dated 10/14/15 were not transcribed to the eMAR. -The blood sugar range was 112 to 372. -There were 25 FSBS between 151-199 for which 2 units of SSI should have been given and none was documented as administered.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 175</p> <p>Review of the resident's November 1-18, 2015, eMAR revealed:</p> <ul style="list-style-type: none"> -SSI coverage was scheduled at 7:30am, 12:30pm, 17:30pm and 20:00pm daily. -The SSI coverage order was transcribed according to the 9/30/15 Physician's Orders and was documented as administered with the same parameters. -The SSI parameters of the hospital discharge summary dated 10/14/15 were not transcribed to the eMAR. -The blood sugar range was 76 to 257. -There were 25 FSBS between the 151-199 for which 2 units should have been given and none were documented as administered. <p>Interview with Resident #25 on 11/19/15 at 10:00am revealed:</p> <ul style="list-style-type: none"> -He relied on the facility to administer his medications according to doctor's orders. -He did not believe his medication changed after he came back from the hospital. -He did not remember how many times he received insulin injections but it was "a lot" and did not know what his blood sugar range was. <p>Interview with a second shift Medication Aide (MA) on 11/18/15 at 3:45pm revealed:</p> <ul style="list-style-type: none"> -She administered the SSI coverage according to the orders on the eMAR. -She was not familiar with the resident's 10/14/15 hospital discharge summary and not aware the SSI coverage ordered on the discharge summary was different than the eMAR. -Usually the Supervisor/MA receiving new orders including FL-2s and discharge summaries, would enter the orders into the eMAR and fax the orders to the pharmacy. -The MAs are supposed to initial the orders when they are entered and then place in the resident's 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 344	<p>Continued From page 176</p> <p>record.</p> <p>Interview with the RCC on 11/18/15 at 4:30pm revealed: -She was aware Resident #25 had been in the hospital. -She was not aware there were medication changes on the discharge summary. -The staff would administer the SSI according to the parameters on the eMAR currently. -The Supervisor or MA who processed the FL-2/discharge summary for Resident #25 should have entered the changes, obtained verification, faxed to pharmacy and initialed and date the discharge summary when completed.</p> <p>Interview with the Primary Care Nurse Practitioner (PCNP) on 11/19/15 at 11:05am revealed: -He was not aware of the 10/14/15 FL-2/hospital discharge summary. -He would expect the facility to have sent a clarification/new order request regarding the dosage discrepancies for the SSI to his office or have available for him to review while in the facility. -He did not recall receiving a clarification for the SSI parameters. -The SSI parameters orders renewed on 9/30/15 would be the parameter he would continue, not the ones ordered by the hospital discharge.</p>	D 344		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 177</p> <p>by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure sliding scale insulin was administered for fingerstick blood sugars (FSBS) as ordered for 1 of 1 sampled resident (#6).</p> <p>The findings are:</p> <p>Review of Resident #6's current FL2 dated 2/27/15 revealed: -Diagnoses included: insulin dependent diabetes. -Medications orders included Finger Stick Blood Sugars (FSBS) three times a day before meals and at bedtime, Novolog (fast acting insulin to lower levels of sugar in the blood) 14 units three times a day before meals, Levemir (long-lasting insulin to control high levels of sugar in the blood) 40 units at bedtime.</p> <p>Review of subsequent orders dated 9/20/15 revealed orders included: -Lantus 25 units at 8am and 2pm. -Novolog 10 units with supper. -Novolog sliding scale insulin (SSI), before meals and bedtime; Blood sugar 150 or less = 0 units Blood sugar 151-200 = 2 units Blood sugar 201-250 = 4 units Blood sugar 251-300 = 6 units Blood sugar 301-350 = 8 units Blood sugar 351-400 = 10 units Blood sugar 401-450 = 12 units Blood sugar 451-500 = 14 units</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 178</p> <p>Blood sugar greater than 500, call MD.</p> <p>Review of subsequent orders dated 9/28/15 revealed Novolog sliding scale insulin orders as follows: FSBS before meals and at bedtime, Blood sugr less than 50 = no Novolog Blood sugar 51-70 = immediately eat, take injection just before eating Blood sugar 71-150 = take prescribed dose Blood sugar 151-200 = 2 units Blood sugar 201-250 = 4 units Blood sugar 251-300 = 6 units Blood sugar 301-350 = 8 units Blood sugar 351-400 = 10 units Blood sugar 401-451 = 12 units Blood suar above 451 contact MD.</p> <p>Review of the September 2015 Electronic Medication Administration Record (e-MARs) revealed: FSBS ranged from 55 to 511. Review of the 5:30pm FSBS results revealed 2 entries of results documented. Examples included: -9/3/15 through 9/30/15 2 sets of documented entries of FSBS results were documented. -One FSBS at 4:30pm and another at 5:30pm. - SSI was not administered 19 out of 26 opportunities as ordered. -SSI units administered were too many or too little units according to the order.</p> <p>Further review of the September 2015 eMAR revealed: -At 5:30pm 2 sets of documented entries for FSBS results. -One FSBS at 4:30pm and another at 5:30pm. -At 8pm 2 sets of documented entries for FSBS results. -One at 8pm and another one at 9pm. -On 9/1/15 through 9/30/15 SSI was not</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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(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 358	<p>Continued From page 179</p> <p>administered as ordered (too many or too little units) included:</p> <ul style="list-style-type: none"> -At 7:30am - 2 times. -At 12:00pm - 1 time. -At 5:30pm - 6 times. -At 8pm - 19 times. <p>Review of the October 2015 e-MARs revealed FSBS ranged from 56 to 511.</p> <ul style="list-style-type: none"> -At 5:30pm 2 sets of documented entries for FSBS results. -One FSBS at 4:30pm and another at 5:30pm. -SSI was not administered 49 out of 69 opportunities as ordered. Examples from 10/1/15 through 10/31/15 of SSI not administered as ordered (too many or too little units) included: -At 7:30am - 9 times. -At 12:00pm - 19 times. -At 5:30pm - 7 times. -At 8pm - 13 times. <p>Review of the November 2015 e-MARs revealed FSBS ranged from 68 to 547.</p> <ul style="list-style-type: none"> -SSI was not administered 13 out 42 opportunities as ordered. Examples from 11/1/15 through 11/19/15 of SSI not administered as ordered (too many or too little units) included: -At 7:30am - 1 time. -At 12:00pm - 2 times. -At 5:30pm - 2 times. -At 8pm - 7 times. <p>Review of emergency room discharge records revealed Resident #6 was transported via ambulance to the hospital for hyperglycemia (high blood sugars) the following dates: -8/17/15, 9/2/15, 9/19/15, 9/27/15, 10/2/15.</p> <p>Interview on 11/13/15 at 11:15am with a Medication Aide (MA) revealed:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 358	<p>Continued From page 180</p> <ul style="list-style-type: none"> -She didn't know why the FSBS were not documented as being completed on the e-MARs. -She did not know why the SSI was not documented correctly. - "If there is not a box to document the results in on the e-MAR, then the FSBS results can't be documented." -They don't document the results or SSI anywhere else. -The Resident Care Coordinator (RCC) would be the person to answer those questions. <p>Interview on 11/13/15 at 11:35am with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -Sometimes when the MARs come from the pharmacy, there was not a box to document the FSBS results. - "I can put the boxes in sometimes and when I am not able to, I have to call the pharmacy to put them on the e-MAR." - "I would assume the staff gave what they were supposed to give." - "There is no other place the staff document FSBS or SSI." - "No paper documentation for the FSBS results or SSI given since we have the e-MAR." - "I'm not sure why the staff wasn't following the new SSI orders or why the FSBS weren't documented as being completed. I don't understand why all the holes are on the e-MAR." - "There should be something documented there instead of having empty spaces." <p>Interview on 11/20/15 at 6:40am with a third shift MA revealed:</p> <ul style="list-style-type: none"> -He did work sometimes on second shift. -He did give insulin and FSBS when he worked on second shift. -He did not know why there were empty spaces on the e-MAR for FSBS and incorrect doses of 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 358	<p>Continued From page 181</p> <p>SSI documented as administered.</p> <p>-The FSBS "pops up twice to be done on the e-MAR. Once at 4:30pm and then again at 5:30pm, so I checked it both times."</p> <p>-He stated he only gave the insluin per the second reading.</p> <p>-I go by the e-MAR when checking FSBS or giving insulin.</p> <p>-I don't read the orders on the box. I don't know why the e-MAR is not right because I go by what's on the e-MAR."</p> <p>-He did not ask anyone about the FSBS "popping up" twice.</p> <p>Interview on 11/20/15 at 10:10am with the RCC revealed:</p> <p>-The pharmacy doesn't always put the boxes on e-MAR and again I presume the staff give the right amount of insulin."</p> <p>Interview on 11/20/15 at 10:10am with a MA revealed:</p> <p>-She stated, "We have to document in three different places on the e-MAR so sometimes it just gets missed."</p> <p>-I guess we need to do some more training."</p> <p>Interview on 11/19/15 at 12:52pm with the dispensing pharmacy staff used for Resident #6's medications revealed:</p> <p>-Normally everything can be put on the electronic Medication Administration Records (eMARs).</p> <p>-It should come through and show on the pharmacy side and on the facility side.</p> <p>-If the medication orders are not showing the facility should contact the pharmacy order entry technician.</p> <p>-The facility eMAR system had been in place for about 3 months.</p> <p>-If facility staff was having problems</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 358	<p>Continued From page 182</p> <p>understanding the system, the pharmacy had people they could send to the facility to help them out, they just needed to call.</p> <p>-The times they show for Resident #6's Novolog sliding scale insulin (SSI) with finger stick blood sugars (FSBS) was 7:30am, 11:30am, 4:30pm and 8:00pm.</p> <p>-Their system does not show a 5:30pm time for Resident #6's FSBS and SSI.</p> <p>-If the facility was entering FSBS and SSI at 5:30pm, then one of the approved entry people at the facility was overriding the system and entering the 5:30pm time on the facility's side.</p> <p>-The 4:30pm time would still show up on the eMARs because that was the time on the physician's order.</p> <p>-It was simple to change the time, the facility just had to fax the pharmacy an order from the physician with the 5:30pm time, then the pharmacy would delete the 4:30pm off the eMAR.</p> <p>-They dispensed Novolog SSI before meals and at bedtime on 10/29/15 and 11/06/15.</p> <p>Second interview on 11/19/15 at 3:37p m with the pharmacy staff revealed:</p> <p>-Resident #6's eMARs show that Novolog SSI before meals and at bedtime had the units of insulin logged for the month October 2015.</p> <p>-The facility staff who had rights to enter, change or delete medication orders and treatments in the eMAR system were: the Program Director, Business Office Manager, both Administrators, and the Resident Care Coordinator.</p> <p>Interview on 11/19/15 at 9am with the facility Family Nurse Practitioner (FNP) revealed:</p> <p>-The guardian told the facility doctors to, "stay away from changing or ordering FSBS or insulin, because the resident sees an endocrinologist."</p> <p>-He was not aware some staff were doing FSBS</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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 358	<p>Continued From page 183</p> <p>at 4:30pm and again at 5:30pm. -He asked if they were giving insulin both times. -"I've not been called about her blood sugars being high. I wonder why they are checking her blood sugar twice. It should be before meals and at bedtime." -"Her blood sugars are up and down like a roller coaster because sometimes she eats and sometimes she doesn't." -"I let endocrinology handle it".</p> <p>Interview on 11/19/15 at 1:47pm with the Operations Manager revealed: -She was not aware of the FSBS results being obtained twice. -She was not aware of the new order for insulin on 9/29/15. -She would check into it.</p> <p>Attempted telephone to the endocrinologist was not returned by exit.</p>	D 358		
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy by routinely crushing controlled drug</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 184</p> <p>medications for all residents when not indicated in all residents' individualized plan of care; by failing to consider the individual needs and privacy of each resident during medication administration by requiring residents to line up in the hallway to receive medications; by failing to administer injectable medications discreetly and in private; failing to respect and ensure the dignity of residents by dressing residents in ill-fitting and tattered clothing that did not belong to the residents; by failing to provide clean sheets for mattresses; and by failing to provide a complete set of flatware to each resident at meal times.</p> <p>The findings are:</p> <p>A. Observations, interviews and review of residents' records revealed no individualization, privacy, or consideration with the facility's procedures for medication administration.</p> <p>1. Observation of medication administration at various times from 11/09/15 to 11/19/15 revealed:</p> <ul style="list-style-type: none"> -The facility had one long hall with residents' rooms located along both sides of the hall. -The hall was divided into 4 sections (100, 200, 300, and 400 sections). -Medications were administered at the medication room, located in the middle of the facility, between the 100-200 sections and the 300-400 sections. -Residents lined up along one wall of the 100-200 section, and one wall of the 300-400 section, at the scheduled medication pass times. -The medication room had 2 stationary half doors that residents from each end of the hall approached to request their medications. (Residents from the 100-200 section used one door and residents from the 300-400 section used the other.) 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 185</p> <p>Observation on 11/9/15 at 12:00pm revealed:</p> <ul style="list-style-type: none"> -A Medication Aide (MA) rolled a male resident in his wheelchair to the half door of the medication room. -The MA performed a finger stick blood glucose check on the resident in the hallway. - The MA prepared an insulin injection, gathered supplies, at the medication cart inside the medication room. -The MA lifted up the resident's shirt and injected insulin in his exposed right abdomen, by reaching over the closed half door. -Residents were in line standing behind the resident and others walked past the resident. <p>Confidential interview with a resident standing in the line at the medication room half door, behind the resident revealed:</p> <ul style="list-style-type: none"> -Residents get their insulin shots, either in their arms or their abdomen, in the hallway. -Residents pulled their shirts up "right in the hallway." <p>Observation of the 8:00am medication pass on 11/10/15 and residents awaiting medication administration on 11/12/15 from 7:00am to 8:32am revealed:</p> <ul style="list-style-type: none"> -Two Personal Care Managers (PCAs) went down the hall knocking on residents door to inform the residents it was time to get up for their medication and breakfast. -Residents from the 100-200 hall and 300-400 hall made their way from their rooms and started to line up on right hand wall, approaching the medication room, respectively. -Two medication carts were positioned, back to back, in the medication room. -Each medication cart had a medication aide administering medications. -Residents stood in line and moved forward as 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 186</p> <p>medications were administered, at the half door, for one after another resident.</p> <p>Observation on 11/12/15 from 7:00am to 9:00am revealed:</p> <ul style="list-style-type: none"> -At 7:00am, one PCA on 100-200 section of the hall knocked on doors to awaken resident. -Between 7:08am and 7:28 am, FSBS were done for 3 residents with 2 of the residents administered insulin. FSBS and the insulin were administered with the residents in the hallway and the medication aide on the other side of the medication door. -A steady line of residents was observed from 7:15am to 8:10am at both half doors. -At 7:50am, one Medication Aide (MA) came out of the medication room to administer medications to a resident on 100-200 section of hall that receives morning medication in his room. -At 8:06am, the MAs provided a list of residents, not yet having received morning medications, to a staff member. -At 8:12am, both MAs out of medication room and full door closed, securing the medication room. (MAs helped with breakfast until 8:20am). -At 8:20am, the medication room doors were opened back up with both stationary half doors in place. -At 8:23am, the staff member was observed going through the list of residents that had not received medications and searching for each resident to inform the resident he/she needed to come to the medication room for medications. -Medication Aides were observed to leave the medication room to administer medications only one time. <p>Interview on 11/12/15 at 8:08am with a staff member revealed:</p> <ul style="list-style-type: none"> -On the days he worked, MA staff gave him a list 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 187</p> <p>of residents that had not received medications by 8:00am.</p> <p>-He stated he was to inform each of the residents on the list that they needed to come to the medication room for medications, according to the house rule.</p> <p>Observation of medication administration for the 300-400 section of the hall on 11/19/15 revealed the following:</p> <p>-At 7:35am 6 residents were in line for medication. One resident was seated on the floor.</p> <p>-At 7:38am one female resident joined the line, holding onto the hand rail with both hands. There were 5 residents in front of her.</p> <p>-At 7:40am, a female resident in a wheel chair joined the 300-400 section line with 4 residents in front of her. At 8:04am, one MA came out of the medication room to take a blood pressure reading for her, in the hallway. She received her medications at 8:08 am.</p> <p>-At 7:43am, the resident seated on the floor stood at the half door and received his medications, including a FSBS.</p> <p>-At 7:45am, the female had moved toward the medication room half door but continued to hold the handrail with both hands and shift from side to side, as if struggling to stand for a long period. At 7:55am, she received her medications. (Previous interview revealed she had trouble standing for long periods of time and sometimes used a chair in the line.)</p> <p>-At 8:10am, no residents were standing at the medication room windows and the MAs closed the doors and joined other staff serving residents in the dining area.</p> <p>-The medication room doors were reopened at 8:20am and 8:23am.</p> <p>-The medication room doors were closed at</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 188</p> <p>9:00am.</p> <p>Interview on 11/16/15 at 1:55 pm with a resident observed receiving insulin over the half door revealed:</p> <ul style="list-style-type: none"> -He received medications including insulin from over the half-door. -Staff administered insulin both in his arm and his lower abdomen, alternating. -MAs had administered his insulin over the half door for more than one year. -He could hide the exposed area when receiving an abdominal injection and he did not have to remove his shirt to receive insulin in his arms. <p>Interview on 11/10/15 at 8:45am with a first shift MA revealed:</p> <ul style="list-style-type: none"> -The residents routinely lined up outside the medication room for medications daily. -The facility had administered medications in this fashion for longer than 2 years. -Residents were supposed to come to the half door when they wanted a medication or medications. -If the full doors were closed, residents should knock on the door for assistance with obtaining medications. <p>Interview on 11/10/15 at 8:45am with a second MA from first shift revealed:</p> <ul style="list-style-type: none"> -She worked at the facility for more than 2 years. -Residents lined up for medications since she had worked at the facility. -She routinely administered insulin injections, finger sticks, and took blood pressure outside the medication room (at the half door). -She was not aware of any resident complaining about receiving medications at the medication room door. -She had at least one resident that she took 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 189</p> <p>medications to the resident's room in the mornings because the resident did not get up until 10:00am.</p> <p>Interview on 11/12/15 at 11:10am with a female diabetic resident revealed:</p> <ul style="list-style-type: none"> -She was uncomfortable with having her shirt pulled up in the hallway to allow staff to administer her insulin. -She stated "I don't want all the men looking at me because I have Post Traumatic Syndrome Disorder (PTSD)." -Continued interview revealed: She doesn't like standing in line to get her medications because, "It makes me feel like a child when I have to stand in line to get my meds." -She stated she had talked to staff but staff told her "that was the way it was" for receiving medications. -She stated she had been taken into the medication room for some treatments but she routinely received medications in the medication line. <p>Interviews on 11/12/15 at 10:20pm, 10:38 pm and 11:30 pm with a second shift and third shift MAs revealed:</p> <ul style="list-style-type: none"> -One MA had worked at the facility for a little more than 45 days. She trained on the medication cart with another second shift MA before she started working alone on the cart. -One MA had worked at the facility for a little more than 4 months and she was trained that the residents were administered insulin by the MA standing in the medication room and discretely injecting the insulin in the lower abdomen or in the arms. -One MA had worked at the facility for 8 years. She stated FSBS were checked, and insulin was administered routinely over the half door, with 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 190</p> <p>residents standing in the hall.</p> <p>-All three MAs stated they were trained that the residents lined up in the hall and came to the window one by one for medications.</p> <p>Interview on 11/16/15 at 1:55 pm with a resident observed receiving insulin over the half door of the medication room revealed:</p> <p>-He received medications including insulin from over the half-door.</p> <p>-Staff administered both in his arm and his lower abdomen, alternating.</p> <p>-He could hide the exposed area when receiving an abdominal injection and he did not have to remove his shirt to receive insulin in his arm.</p> <p>Interview on 11/16/15 at 2:32 pm with a resident, observed later on 11/19/15 holding onto the rail and shifting side to side, revealed:</p> <p>-She does not ambulate very well.</p> <p>-She experienced a lot of pain in her legs when she had to stand in the medication line.</p> <p>-She used a chair to sit down on some days when she was in the medication line.</p> <p>-Residents said things that made her feel bad because she moved the chair along in the medication line.</p> <p>-MA staff do not routinely administer medications in residents' rooms.</p> <p>Interview on 11/16/15 at 2:50 pm with a resident revealed:</p> <p>-He did not like standing in line for his medication.</p> <p>-He squatted down to keep his legs from hurting.</p> <p>-The medication line was a "problem" because the residents sometimes got in arguments.</p> <p>-Two residents got in an altercation yesterday (11/15/15) in the medication line.</p> <p>Interview on 11/18/15 at 9:00am with a resident</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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(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
D911	<p>Continued From page 191</p> <p>revealed he did not like waiting in line for medications, so he waited until the line went down before going for medications.</p> <p>Confidential interview with a resident revealed: -He was sick of standing in line for medications. -Some residents were rude and did not stand in a single line, but out in the walkway, and you had to walk around the residents to get in line. -Standing in line for medications was tedious, exacerbating, and frustrating. -"If he did not have to stand in line he would feel self-fulfilled."</p> <p>Confidential interview with a resident revealed: -Residents would sit down in chairs while waiting in line for their medications. -The medication aides would "fuss at" residents for sitting in chairs as it was a "fire hazard".</p> <p>Confidential interview with a resident revealed: -"I am supposed to go down there [to the medication room]." -Staff might take medications to some other residents "but not me."</p> <p>Confidential interviews with additional residents revealed statements as follows: -I don't like having to stand in line to get my meds, but, "If we don't come to the med room, we won't get our meds." -Residents "Have to knock on med room door to get medication" except during the medication passes. (Residents were observed knocking on closed med room doors on multiple occasions from 11/9/15 to 11/19/15). -Fights have occurred between residents in the medication line. -"Do not get medications if do not go to med room."</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D911	<p>Continued From page 192</p> <p>- "Men and women" expose their abdomens while standing in the medication line while receiving insulin injections.</p> <p>- One resident received his medications at the medication room and staff would "get [expletive] off if I miss my med[medication] time."</p> <p>Review of the facility's documented accident/injury reports revealed a report dated 6/29/15 describing a confrontation in the medication line in which a resident in a wheelchair "punched a female" resident in the face after she pushed his wheelchair while he was in the medication line.</p> <p>Interview on 11/17/15 at 2:52pm with the Resident Care Coordinator (RCC) revealed:</p> <p>- She did not recall when staff started administering insulin at the medication room half door.</p> <p>- Medication Aides have always administered insulin over the half door from the medication room to residents in the hallway.</p> <p>- She mentioned two residents by name whom she had heard medication aides ask if they wanted to come into the medication room for their insulin and they would say no.</p> <p>- She was not aware of any resident complaints regarding their receiving insulin administered in the hallway.</p> <p>- At one time medication aides would push their medication carts down the hallway but residents would try to take stuff off the carts and "it did not work."</p> <p>- Residents that have trouble standing can wait in the day room next to the medication room until the line clears and walk up to the medication room.</p> <p>- Residents were permitted to sit while waiting for their medications and if they let the medication</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 193</p> <p>aides know then they could get their medications.</p> <p>2. Observation of medication administration at various times from 11/10/15 to 11/19/15 on 11/10/15 revealed controlled drug medications were crushed and administered mixed in applesauce for residents.</p> <p>Two residents were observed being administered controlled drug medications, clonazepam 1.0 mg (used to treat anxiety), and hydrocodone with APAP 10/325 (combination narcotic pain reliever and acetaminophen used to treat pain) for Resident #4, and diazepam 10 mg (used to treat anxiety) for Resident #23, during the medication passes on 11/10/15 at 8:00am and 3:56pm.</p> <p>Observation on 11/10/15 at 8:00am of the medication pass and review of Resident #23's record revealed:</p> <ul style="list-style-type: none"> - A current FL-2 dated 7/9/15 with diagnoses included schizophrenia disorder, and history of alcohol abuse. (No information for crushing medications.) -Resident #23 received one diazepam 10mg tablet crushed and added to one teaspoonful of applesauce. -No documentation for an order to crush medications for the resident. -The 6 months signed physician medication renewal dated 9/30/15 that had no notation of "May crush all meds that can be crushed". <p>Observation on 11/10/15 at 3:56 pm of the 4:00 pm medication pass and review of Resident #4's record revealed:</p> <ul style="list-style-type: none"> -A current FL-2 dated 10/6/15 for Resident #4 with diagnoses including rheumatoid arthritis, and schizophrenia paranoid type. (No information for crushing medications on the FL-2.) 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 194</p> <p>-Resident #4 received one clonazepam 1.0 mg (a controlled drug medication used to treat anxiety) and one hydrocodone with APAP 10/325 (a controlled drug narcotic pain reliever) crushed and added to one teaspoonful of applesauce.</p> <p>-Resident was requested to open mouth for medication aide to observe if the medication was swallowed.</p> <p>-A previous 6 months signed physician order dated 9/30/15 with a notation of "May crush all meds that can be crushed. See list of meds that can't be crushed."</p> <p>Interview on 11/13/15 at 12:00pm with Resident #4 revealed:</p> <p>-He was not sure why part of his medications were administered in applesauce.</p> <p>-He did not have any objection with part of his medication being administered in applesauce.</p> <p>Interview on 11/10/15 at 8:45am with a MA from first shift revealed:</p> <p>-She worked at the facility for more than 2 years.</p> <p>-She routinely administered all controlled drugs (narcotic pain relievers, anti-anxiety medications) crushed and mixed in applesauce unless the medication was labeled do not crush.</p> <p>-She had been told when she was hired this process prevented residents from "cheeking" (holding medications in the cheek and later remove) medications.</p> <p>Interviews on 11/12/15 at 10:20pm to 11:30pm 3 MA's revealed:</p> <p>-Most of the residents' controlled drug medications were crushed and added to applesauce which prevented residents from "cheeking" medication.</p> <p>-Every resident's controlled drug medications was crushed and added to applesauce which</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 195</p> <p>prevented residents from "cheeking" medications. -Residents' controlled drug medications were routinely crushed and added to applesauce unless medications were labeled for "Do not Crush". -She thought the medications were crushed to prevent residents from "cheeking" the medications.</p> <p>Interview on 11/17/15 at 2:52pm with the Resident Care Coordinator (RCC) revealed: -Medication Aides were routinely crushing controlled medications before she was employed by the facility. -She was not sure if individual resident assessments were done to determine if "cheeking" of controlled medications was occurring with some residents. -The crushing of medications was on the standing orders but no assessment was required. -The policy to routinely crush controlled medications was passed down from management and that was how she was taught when oriented to the medication cart. -She was not aware of any residents having problems with routine crushing of medications. -Occasionally there was a resident that did not like applesauce and the medication could be put in a pudding. -Providers were aware that medication aides were routinely crushing controlled medications. -She was aware of one or two residents that had currently been identified as residents that had a history of "cheeking" medications.</p> <p>Interview on 11/18/15 at 1:58pm with the Operations Manager revealed: -She was not sure when the crushing of all controlled drug medications and placing in applesauce began in the facility.</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 196</p> <p>-If a resident had a history of "cheeking" medications then the facility would surely get a routine crush order.</p> <p>-The contract pharmacy printing the order "May crush all meds that can be crushed. See list of meds that can't be crushed" was what the facility used for the crush order for controlled drugs.</p> <p>-She was not aware if the residents' physicians had done an assessment or review for the need to crush medication on each patient that had controlled drugs currently being crushed.</p> <p>Interview on 11/19/15 at 12:08pm with one of the facility's mental health Family Nurse Practitioner revealed:</p> <p>-She was not aware residents she treated in the facility had controlled drug medications routinely crushed.</p> <p>-She stated the facility should be assessing each resident for the need for crushing medications.</p> <p>-She stated the practitioner usually evaluated the individual resident before authorizing medications to be crushed.</p> <p>B. Observation in the laundry room on 11/13/15 at 10:00 am revealed:</p> <p>-A Personal Care Aide (PCA) was folding laundry (clothing) and placing them on a worktable.</p> <p>-There was two large stacks of clothing already folded on the worktable.</p> <p>-Two dryers and 2 washers were operating, full of linens and clothing.</p> <p>Interview with the PCA in the laundry room at 10:00 am on 11/13/15 revealed:</p> <p>-All PCAs do laundry during their shift.</p> <p>-She alternated facility laundry with personal laundry.</p> <p>-The clothing stacked on the worktable are not labeled with resident names and will be used by</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 197</p> <p>the staff responsible for baths to clothe residents who do not have clothing.</p> <p>-There was also another room which contained clothing not labeled as belonging to residents which are used for residents.</p> <p>Interview with another PCA on 11/16/15 at 2:00 pm revealed:</p> <p>-The clothes stacked on the table "don't belong to anyone" and are not labeled with a resident name.</p> <p>-The clothes are used by all residents.</p> <p>-She stated "Some residents can't keep clothes in room because they sell or trade them.</p> <p>-The PCA stated she did not have a key to the other storage room.</p> <p>Observation of the other "storage" for clothing (Room 402) on 11/16/15 at 2:07 pm revealed:</p> <p>-The room was cluttered and packed with 4 large black trash bags of "clothes".</p> <p>-There was loose clothing scattered all over the surfaces of the room in a random and chaotic manner.</p> <p>-Some clothing was laying on the floor in stacks.</p> <p>-There were furniture items and equipment stored amongst the clothing.</p> <p>Interview with the housekeeper who unlocked the room on 11/16/15 at 2:07 pm revealed:</p> <p>-PCAs did not have a key to this room.</p> <p>-This clothing was in addition to what was stored in the laundry room.</p> <p>-The clothing was different sizes and not sorted according to size.</p> <p>-The generic clothing was usually put on a rolling cart and wheeled around and offered to residents.</p> <p>-If a resident had no clothes on bath days, the clothing would be offered to them.</p> <p>-Stated "residents throw clothing away all the</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 198</p> <p>time." -The "bath cart" was stocked with towels, wash cloths, personal care items and clothing for who might need them during shower times.</p> <p>Observation on 11/16/15 at 2:30 pm of the shower cart in the 100 Hall bathroom revealed: -This bathroom was used for bathing and usually kept locked. -The bath cart was kept in the bathroom after stocked. -There was clothing on the cart-one pair of underwear, on pair of socks, shirt, and a large size of sweat pants. -There were also a small number of towels and wash cloths and personal hygiene items.</p> <p>Interview with the PCA primarily responsible for baths on 11/17/15 at 7:55 am revealed: -She was responsible for seeing the baths were given and completed and refusals documented. -She usually got clothing from the laundry room ahead of scheduled bathing times and put it on the bath cart. -One resident regularly gave away his clothes brought in by his family. -If the resident's clothing was labeled with his name, he would get the clothing back when they are laundered.</p> <p>Observation in the laundry room on 11/17/15 at 3:55 pm revealed; -A PCA was in the room going through the clothes stacked and folded on the worktable. -She stated she was getting ready to assist a resident with his bath and needed clean clothes for him to put on after bathing. -He does not have his own clothes, but used the clothing off the table or in storage.</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 199</p> <p>Confidential interview with a resident's guardian revealed:</p> <ul style="list-style-type: none"> -The guardian visited the facility monthly and every time she visited she had to replace shoes, clothes and under garments. -The guardian revealed she was upset because it was not unusual to see her relative's clothing or shoes on another resident. -When she told the Operations Manager about seeing her relative's items on another resident, the Operations Manager's response was "hum, that's what they do here, take others clothes". -She had even marked her family member's name on all the items that she left at the facility, but when she returned they were all gone. <p>Interview with the Resident Care Coordinator (RCC) on 11/17/15 at 2:52pm revealed:</p> <ul style="list-style-type: none"> -Residents were known to trade clothes for cigarettes "behind staff backs" even though they were told not to barter, sell or trade in the facility. -Many residents traded their clothes with other residents and one (mentioned by name) was known to trade his clothes for cigarettes. <p>Interview on 11/16/15 at 3:12 pm with a resident revealed:-</p> <ul style="list-style-type: none"> -He had 3 pairs of jeans and biker shirt stolen. -The pants had his initials on the inside pocket label. -The biker shirt had not shown up. -He reported the instance to the Operations Director and she said the facility was not responsible. -He stated it had been about 2 weeks. -"Residents sell clothes, CDs, and cigarettes". <p>Observation in the 100 Hall Bath on 11/17/15 at 9:40 am revealed:</p> <ul style="list-style-type: none"> -The PCA had brought a shirt and blue jeans for 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D911	<p>Continued From page 200</p> <p>the resident receiving a bath from home.</p> <ul style="list-style-type: none"> -The resident had his own underwear, brought from his room. -The blue jeans brought this morning from the PCA's home were too big. -The resident was dressed in a pair of sweat pants off the bath cart. <p>Interviews and observations of 5 residents, one female and four male residents, on 11/18/15 between 8:15 am and 9:30 am revealed:</p> <ul style="list-style-type: none"> -One female resident needed staff assistance with showers. -In the resident's closet there were 5 tops; no under pants, and no skirts. -The clothes she had on was not hers, but given to her by staff. -She wore her one skirt all week long and the staff washed it on the weekend while she wore her only pair of pants. -One resident had 1 pair of pants and 2 pair of underwear. -"A man comes every three months and bring him pants, but someone steals them out of his drawers." -The resident had on pants with a 2-inch rip across the buttocks. -One resident had no clothes and 1 pair of socks in his dresser. -The resident reported staff let him borrow clothes to put on when he showered. -He did not mind that the clothes were not his because they were clean. -One resident had on pants that were falling down and the resident's bare skin was showing. -The resident said the pants had elastic around the waist and the elastic was loose, causing the pants and underwear to fall down. -He needed a belt for his other pants but did not have one. 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 201</p> <ul style="list-style-type: none"> -He hoped the activity director would give him a belt for Christmas. -Another male resident said he had no clothes, underwear or socks in the room. -When he took a shower staff gave him clothes. -He was okay about them bringing him clothes. -The clothes he had on now were put on 11/16/15. <p>-Observation in Room 309 at 9:15 am on 11/18/15 am revealed the dresser drawers were empty, nothing in the drawers or closet. There were three residents in this room.</p> <p>Interview and observation with a male resident at 9:26 am on 11/18/15 revealed:</p> <ul style="list-style-type: none"> -The resident said he had pants (dress and blue jeans) but staff took them. -He heard they put them in a dumpster. -He needed pants and shorts. -A staff assisted with showers and gave him clothes to put on after the shower. -Another person that visits the facility gives him shirts. -He had no underwear or socks. -He was unable to recall the last time he took a shower. -He had no items to brush his teeth, he was unable to recall the last time he brushed his teeth. -His pants were falling down. -The resident was observed to hold his pants up with one hand when walking. -He said the belt was not good, so he folded the top down a couple of times to keep the pants from falling down. -He had a short sleeve shirts in a suit case on the closet self. -He needed clothes "what should I do?" <p>Observation of a resident on 11/12/15, 11/13/15,</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 202</p> <p>11/16/15 and 11/17/15 revealed"</p> <ul style="list-style-type: none"> -This resident wore a pair of dark brown pants with a 2 inch torn, and worn patch over his right buttocks. -He wore the same clothing each day. -On the afternoon of 11/17/15, he had another pair of pants on that were not worn through. <p>Interview with the Vice President of Operations on 11/17/15 at 3:55 pm revealed:</p> <ul style="list-style-type: none"> -The residents sell and trade clothes all the time. -One resident sold his underwear for cigarettes. -Clothing with no names on them probably came from a thrift shop. -"Some of the residents were homeless and came with just the clothes on their back." -She was not aware residents were "upset" seeing other resident wearing the same clothing themselves had worn. <p>Observations on 11/9/15 to 11/19/15 at various times of residents and their personal appearance and clothing revealed:</p> <ol style="list-style-type: none"> 1. On 11/9/15 at 10:15AM outside of the facility revealed; a resident wearing a quilted outerwear jacket. The jacket was visibly torn across the entire front, exposing a fiber fill with whole pieces of outer fabric completely missing from the jacket. 2. On 11/9/15 at 11:05am of a female resident in the hallway revealed; A coat buttoned up crooked. Several large holes on the front and back of the coat. Pieces of the coat's material was tore and hanging from the coat. 3. On 11/9/15 at 11:40am of another resident in the hallway revealed a resident wearing a jean material coat. The coat was visibly dirty. 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D911	<p>Continued From page 203</p> <p>4. On 11/9/15 at 12:55pm of the dining room during lunch service revealed; One resident wearing a white outerwear jacket that was visibly dirty all over the jacket. One resident wearing an outerwear jacket and flannel pajama bottoms.</p> <p>5. On 11/9/15 at 1:10pm of a resident in the dining room revealed; He was wearing a pullover sweatshirt. The cuffs were pulled apart with strings hanging off the edge of the sleeves. The cuffs had holes in them. The arms had dime-sized to quarter-sized holes. Around the neck of the sweatshirt, the string to tighten the hood was missing and had dime-sized holes where the string should have been. The sweatshirt had food and stains down the front of it.</p> <p>6. On 11/9/15 at 3:50pm of a female resident revealed; She was wearing a white coat. There were large black areas and stains all over the coat. The cuffs, collar and front of the coat were highly soiled and dirty. The coat was ripped in several places. She was also wearing an off-white sweater showing from under the coat. The sweater had large black areas around the cuffs and bottom. The resident continued to wear the coat throughout the survey. The resident was wearing a different coat the last two days of the survey (11/18/15 and 11/19/15.)</p> <p>Interview on 11/9/15 at 3:50pm with the resident revealed: -The coat had not been washed "in quite a while." -She did not elaborate on "quite a while." -"The Operations Manager told me she last week she was going to take it home and wash it with bleach. -Staff would wash her clothes if she had a</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D911	<p>Continued From page 204</p> <p>basketful.</p> <p>-There was "no schedule" to luadering of clothes.</p> <p>-They don't use bleach here on our clothes."</p> <p>-The Operations Manager had not taken it home yet to wash.</p> <p>7. On 11/10/15 at 10:45am in the hallway outside the medication room revealed; An unnamed male resident requesting one of the medication aides. His hair was unwashed and not combed. He was wearing denim jeans too big for his waist and the length too long for his height (the cuffs of the jeans were pulled up approximately 8 inches from the floor).</p> <p>8. On 11/11/15 at 10:00am of a resident outside revealed; He was wearing black ankle high boots. The shoelace on the right boot was broken and retied but too short to go through all the eyelets. Both boots had missing and cracked exterior leather-like material, exposing the inner layer of the boot.</p> <p>Confidential interview with a resident revealed: -He had his boots for 2-3 years. -He needed a new pair and would buy them.</p> <p>9. On 11/12/15 at 12:00pm of a male resident on the hall revealed; The resident was wearing a white pullover sweatshirt. The sweatshirt had black stains all over the front and back. The sweatshirt had red and green paint stains on the front and sleeves. He was wearing a pair of thin blue jeans that were too big and wrapped on the sides. The jeans had a black string or rope in the belt loops and tied in the front to hold them up.</p> <p>Interview attempted on 11/12/15 at 12:00pm with above resident was unsuccessful due to resident talking about his room and a book.</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 205</p> <p>10. On 11/16/15 at 3:02pm of a male resident revealed; He was seated in the TV room by the medication room. His pants had a dime-sized hole in the right thigh area, a torn right cuff and both cuffs were folded up as the pants were too long. He lifted his red-striped shirt to reveal a dirty, yellowed printed t-shirt.</p> <p>11. On 11/18/15 at 10:30am of two male residents coming out of Room 409 revealed; Both resident's hair was stringy and matted to their head. Their clothes were dirty, stained and ripped. Both male resident's were wearing tennis shoes that were ripped on the sides and dirty.</p> <p>Attempted interview on 11/18/15 at 10:30am with both male residents was refused due to being upset and agitated their coffee pot and microwave had been removed from their room by the facility.</p> <p>12. On 11/18/15 at 10:05am of a male resident in the dayroom revealed; He was wearing a burgundy shirt with a large black stain in the middle of the shirt. He was wearing a pair of blue jeans with golf ball size holes in both knees of the jeans.</p> <p>Interview on 11/18/15 at 10:05am with the resident revealed: -This was his only clothes. -He did not have any other clothes in his room. -He washed his clothes a week ago. -The facility did not wash his clothes.</p> <p>12. On 11/18/15 at 10:10am of Resident #16 revealed; Resident was wearing the same clothes he had been wearing since 11/10/15. He was wearing a pair of brown pants with a fifty cent</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 206</p> <p>piece size hole under the back right pocket revealing his dark underwear. He was wearing the same silver pullover shirt.</p> <p>13. On 11/18/15 at 1:00pm of Resident #16 revealed: The resident had a shower and was wearing clean clothes. The resident was wearing a pair of blue jogging pants and a white sleeveless t-shirt.</p> <p>14. On 11/19/15 at 3:25pm of Resident #16 revealed he was wearing the same blue jogging pants and white sleeveless t-shirt as the day before (11/18/15).</p> <p>C. Observation of resident room #101 on 11/9/15 at 3:50pm revealed: -There was no sheet on the Residents' bed. -There was a blanket, bedspread and a pillow on the bed. -The pillowcase was dingy and stained. -There was a pile of clothes at the foot of the bed. -The mattress was covered with a clear plastic covering, no sheet.</p> <p>Interview on 11/9/15 at 3:50pm with the resident in room #101 revealed: -She usually had a sheet to cover her bed but she missed getting the sheet from staff today. -She would like to have sheet on her bed. -She stated she had slept on the mattress several times with no sheet.</p> <p>Observation on 11/9/15 at 3:30pm of resident room #105 revealed: - A bare green vinyl covered mattress on the bed against the wall with the window. - Numerous strips of dark colored duct tape stretched horizontally across the middle section of the mattress, the longest tape strips</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 207</p> <p>approximately 2 feet in length.</p> <ul style="list-style-type: none"> -The mattress was dirty, dingy and had black marks on it. -There was no sheet on the mattress. <p>Observation throughout the survey 11/9/15 to 11/19/15 of the beds in room #105 revealed no sheets on either mattress.</p> <p>D. Observation on 11/19/15 at 10:45am one resident in the hallway of the facility revealed:</p> <ul style="list-style-type: none"> -The resident stopped the surveyor and stated "It's not fair that I am not allowed a cup of coffee because did not want to eat breakfast." -The resident revealed coffee was only given out at breakfast time. -Because he did not want to eat the breakfast meal he was not allowed coffee. <p>Interview on 11/19/15 at 4:20pm with the cook revealed:</p> <ul style="list-style-type: none"> -The resident had asked for coffee and she did not give him any because he did not eat breakfast. -She told the RCC and she said ok. -The coffee was only given out at breakfast time. -"That's the way it has always been since I've been here, not to give coffee except at breakfast." -If I give him some then everyone in the facility will want some. -He had been on fluid restrictions because he only wanted to drink and not eat. -The resident had a history of missing meals, and to encourage the resident to eat meals he was given milk with crackers for a snack. However, if the resident did not eat he was not allowed a cup of coffee, milk and crackers for snack as an incentive to eat his meal. -To encourage the resident to eat more food he was additionally offered a second cup of milk with 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 208</p> <p>snacks.</p> <ul style="list-style-type: none"> -This was done because the cook knew the resident liked milk and she wanted him to eat meals to keep his weight up. -If the resident did not eat his meals (breakfast and lunch) he was not given the additional cup of milk, even if he wanted more milk. -The resident in question had not eaten his breakfast and lunch meals, so he was not allowed coffee, and was given 1 cup of milk with saltine square crackers at lunch time. -A previous cook told her that was the routine for this resident. -The instructions came from the Resident Care Coordinator (RCC). <p>Interview on 11/19/15 at 4:35pm with the RCC revealed:</p> <ul style="list-style-type: none"> -The cook in the kitchen told the resident if he eats his meals, then she will give him a second cup of milk with this snacks. -She was unaware the cook was not giving milk for snack if the resident did not eat. -It was the facility's policy to only give coffee at breakfast. -Residents like to sleep late, miss the breakfast time, then get up wanting coffee, and it's too late. <p>Confidential interviews with 3 residents revealed:</p> <ul style="list-style-type: none"> -We only get coffee at breakfast. -We would like to have coffee more often. -Staff told us it's not in the budget to have coffee except at breakfast. -Kitchen staff takes long breaks and when the food is served and it's cold. They refuse to warm it up. -Staff won't serve condiments with the meals or they won't bring them until we are finished with our meal. -"They serve the same food over and over, just 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 209</p> <p>served a different way." -"We would like to have some pork, chicken, beef, tacos, corn dogs." -"Staff refused to give a resident a sandwich and I was sitting next to him and he hit me taking his anger out on me (10/7/15)."</p> <p>E. Refer to Tag 287 10A NCAC 13F .0904 Nutrition And Food Service. Based on observation, interview and record review, the facility failed to ensure residents received a complete set of flatware that included a knife and fork in order for residents to eat their meals without having to wait for assistance from staff to cut up food or having to use their hands to eat food that could be not be cut or eaten with only a spoon.</p> <p>_____ A plan of protection was submitted by the facility on 11/18/15 with an addendum submitted on 11/30/15 that included: -Medication aides will invite residents to come in the medication room, behind closed doors, to administer insulin injections to provide additional privacy for the resident. -Facility staff will attempt to redirect residents lining up for medications. -Staff will begin working on different processes for administering medications to provide additional privacy for each resident. -Each resident will be assessed by primary care physician (PCP) if crush order for medications is needed. PCP is scheduled to be at the facility 11/19/15. Medications orders will be followed until a discontinue order is obtained by the PCP 11/19/15. -Each resident will be assessed by PCP to determine if spoon only order is appropriate. -Recently the facility has been requesting donations of clothing for residents in need. A</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D911	<p>Continued From page 210</p> <p>large donation of clothing was received. Facility staff will begin process of sorting donated clothing as soon as we have access to area where clothing is currently stored (state is currently using this area and preventing us from working on these clothes). Clothing will be cleaned properly and clothing items will be labeled with resident's name as soon as we obtain access to this area.</p> <p>_____</p> <p>The violations resulted in substantial risk of serious neglect and abuse to residents as evidenced by the facility ' s failure to treat residents with respect, consideration, dignity, and full recognition of his or her individuality by the lack of privacy provided during administration of medications, especially the administration of injections and the house rule for residents to line up in the hallway routinely for medications and the crushing of controlled drugs for all residents; failing to respect and ensure the dignity of residents by dressing residents in ill-fitting and tattered clothing that did not belong to the residents; and by failing to provide a complete set of flatware to any resident at meal times.</p> <p>DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2015.</p>	D911		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D912	<p>Continued From page 211</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to management of facilities, personal care and other staffing and personal and supervision.</p> <p>The findings are:</p> <p>A. Based on record review, observation and interview, the facility failed to assure staffing met minimal requirements according to census for 5 of 16 night shifts from October 16, 2015 through October 31, 2015 and in addition, the facility failed to meet the needs of the residents identified in the areas of supervision and resident rights. [Refer to Tag 188, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (B Violation)].</p> <p>B. Based on observation and interview, the facility failed to assure any assigned housekeeping tasks (facility and resident laundry) by aides were limited to occasional, non-routine tasks between 7:00 am and 9:00 pm. [Refer to Tag 206, 10A NCAC 13F .0604(2-B) Personal Care and Other Staffing (B Violation)].</p> <p>C. Based on observation, record review and interviews, the facility failed to assure referral and/or physician notification for 1 of 1 sampled resident who was deemed incompetent, known by staff to be sexually active, and at a higher risk of pregnancy due to antibiotic therapy, and the resident became pregnant (#26); 1 of 1 sampled resident with unabated hoarding (#21); 1 of 6 sampled residents regarding refusing blood</p>	D912		
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Division of Health Service Regulation

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D912	Continued From page 212 pressure checks and fingerstick blood sugar checks (#17); and, 1 of 6 sampled residents refusing medications (#22). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (B Violation)]. D. Based on interview, observation and record review, the facility failed to assure at least 14 hours of planned group activities were provided each week for the residents that promoted socialization, physical interaction, group accomplishment, and learning of new skills. [Refer to Tag 317, 10A NCAC 13F .0905(d) Activities (B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interveiw and recrod review, the faciltiy failed to ensure residents were free of neglect, abuse and exploitation as evidenced by the hazardous condition of the facility, resident rooms and residents' medical equipment; admission of residents with aggressive and dangerous behaviors and were not adequately supervised; improper use of work programs and the lack of supervision/monitoring related to safety for the residents. The findings are: A. Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D914	<p>Continued From page 213</p> <p>facility protect residents from abuse, neglect, and exploitation and treat residents with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy, which resulted in injury to several residents, a resident becoming pregnant, a resident setting a fire in the facility, and implementation of a resident work program that was used as a tool for discipline and coercion and the lack of individualization and privacy related to medication administration. The facility failed to provide appropriate care and services as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the administrator. The administrator is responsible for the total operation of the facility and is responsible for ensuring the implementation of resident rights. [Refer to tag 980, G.S. 131D-25 Implementation (A1 Violation)].</p> <p>B. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 of 6 sampled residents as evidenced by one resident, who was deemed incompetent, known by staff to be sexually active and at a higher risk of pregnancy due to antibiotic therapy and resident became pregnant (#26); one resident who was a known smoker and had a known history of starting fires resulting in a fire at the facility (#2) and for various residents with history of repeated smoking in the facility. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (A1 Violation)].</p> <p>C. Based on observation, interview, and record review, the facility failed to protect residents from abuse, neglect, and exploitation by failing to protect residents from physical assaults resulting</p>	D914		

Division of Health Service Regulation

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D914	<p>Continued From page 214</p> <p>in injury to residents; by admitting residents with aggressive, and dangerous behaviors; by failing to discharge residents with aggressive, and dangerous behaviors; by implementing a resident work program that was used as a tool for discipline and coercion and for which residents were not given fair or equitable compensation for work completed that benefited the facility; by failing to properly maintain and repair durable medical equipment for four residents (#7, #8, #19 and #20); by failing to manage a resident's hoarding behavior which resulted in a safety hazard and cockroach infestation in the resident's room; and neglect by failing to provide a plan to ensure 2 of 2 sampled residents (#3 and #6) with diminished mental capacity were engaging in safe sex practices and with consent. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (A1 Violation)].</p> <p>D. Based on observation, interview and record review, the facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy by routinely crushing controlled drug medications for all residents when not indicated in all residents' individualized plan of care; by failing to consider the individual needs and privacy of each resident during medication administration by requiring residents to line up in the hallway to receive medications; by failing to administer injectable medications discreetly and in private; failing to respect and ensure the dignity of residents by dressing residents in ill-fitting and tattered clothing that did not belong to the residents; by failing to provide clean sheets for mattresses; and by failing to provide a complete set of flatware to each resident at meal times. [Refer to Tag 911, 10A NCAC 13F G.S. § 131D-21(1) Declaration of Resident's Rights</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D914	Continued From page 215 (Type A2 Violation)]. E. Based on observation, record reviews and interviews, the facility failed to correct multiple hazards, which include excessive clutter in 1 resident room (Room #200); for not using approved surge protection devices to prevent overloading of electrical outlets and having cracked outlet faceplates for 4 resident rooms (Rooms #105, #208, #303 and #410); for not effectively controlling for cockroaches throughout the facility and for not repairing a loose metal baseboard heater cover in 1 resident room (Room #105). [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (B Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility protect residents from abuse, neglect, and exploitation and treat residents with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy, which resulted in injury to several residents, a resident becoming pregnant, a resident setting a fire in the	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 216</p> <p>facility, and implementation of a resident work program that was used as a tool for discipline and coercion and the lack of individualization and privacy related to medication administration. The facility failed to provide appropriate care and services as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the administrator. The administrator is responsible for the total operation of the facility and is responsible for ensuring the implementation of resident rights.</p> <p>The findings are:</p> <p>The following findings illustrate the administrator's failure to provide appropriate management, operations, and policies to protect residents and enable residents to attain and maintain the highest practicable level of physical, emotional, and social well-being:</p> <p>Observations of the facility during the various days and times of the survey revealed:</p> <ul style="list-style-type: none"> -Residents were observed sitting in chairs or on the hallway floor outside of the Operations Managers office waiting to speak with her. -A sign on the Operation Manager's office door that read, "Want to see (finance staff name) or (Operations Manager's name)? Please see (Assistant Operation Manager's name) to make an appointment. This door will not open just because you bang on it!" -Medication aides and management staff were in offices or medication rooms and seldom observed on the hallway. -The Vice President of Operations' office was in a portable office trailer located approximately 40 yards adjacent to the front entrance to the facility. The Operations Manager, if not in her office in the 	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D980	<p>Continued From page 217</p> <p>facility, was usually found in the Vice President of Operation's office.</p> <p>-Visualization of the OM's office revealed several monitor screens on her desk showing various views of the facility and residents from video cameras located throughout the facility.</p> <p>Interview on 11/17/15 at 2:50pm with the Operations Manager revealed:</p> <p>-All the departments answered to her.</p> <p>-The Resident Care Coordinator (RCC) handled all the clinical aspects of the facility, such as medications, providing care, and physician appointments and visits. If she had problems she would bring them to me.</p> <p>-She was usually at the facility Monday-Friday and was on-call 24/7.</p> <p>Further observation of the facility during the various days and times of the survey revealed the Administrator was not on-site. The Vice President of Operations or Operations Manager would contact him by telephone if needed.</p> <p>Confidential interviews with 3 residents regarding staff monitoring and supervision revealed:</p> <p>-One resident stated staff were usually "shut-up" in the med room.</p> <p>-Some staff were out on the floor doing work and laundry.</p> <p>-The Administrator/owner was in the trailer almost daily, "he never comes around and speak to residents."</p> <p>-Several residents stated that staff are "hateful."</p> <p>A. Based on observations, record reviews and interviews the facility failed to assure proper care, and staffing necessary to identify, manage and supervise residents with aggressive behaviors which resulted in in resident to resident abuse,</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 218</p> <p>fighting and physical altercations and injury to several residents.</p> <p>Review of facility's Accident/Injury reports revealed from 5/5/15 to 11/16/15 there were 43 reports of physical altercations between residents, 15 of these incidents resulted in injury to one or both of the residents involved .</p> <p>Review of McDowell County Sheriff's communications call log revealed a total of 202 calls from 5/2/15 through 11/5/15 (approximately six months) made from Cedarbrook Residential Care Facility to the McDowell County Sheriff's Office included 26 calls made for physical assaults and fights between residents. Two of these calls were for physical assaults between a resident and staff member.</p> <p>Random interviews with 18 residents from 11/9/15 to 11/19/15 revealed:</p> <ul style="list-style-type: none"> -A resident stated he had been attacked during the night (could not say which night) and punched in the chest and back. He thought the attack may have been "pay back" but was not able to explain. -One resident stated he had been struck by the same resident two different times with a soda can. He stated one of the times he received stitches. -"This place [facility] is more carefree and had not as many rules and guidelines. Had drama like fights, drug busts and prostitution sex." -"Staff refused to give a resident a sandwich and I was sitting next to him and he hit me taking his anger out on me." -A resident threatens me and the staff didn't do anything about it. -Some days I don't feel safe here because of the threats and fights. -One certain resident likes to fight and he bangs 	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 219</p> <p>on doors. Staff calls crisis but it doesn't help.</p> <p>-One resident said "I don't feel secure at all."</p> <p>-Two residents got in a fight yesterday (11/15/15). Two staff witnessed the fight.</p> <p>-One resident tried to "jump on" him about six months ago. The resident came running across the yard cursing and jumped on him. He tried to defend himself.</p> <p>-They (residents) fight all the time.</p> <p>-Some residents fight over "weed," boyfriend, girlfriend or for no reason.</p> <p>-One resident sold coffee on credit and if people don't pay he wanted to fight them.</p> <p>-A female resident stated a male resident at the facility hit her because he did not want to eat the meal, he wanted a cheese sandwich. The male resident threatened her, saying he was going to punch her again. She told staff and staff said to just "brush-it off". Resident (male) tries to fight females, staff calls crisis hotline. The same male resident choked her once, because she got into an argument with this girlfriend.</p> <p>-A resident stated they "have lots of things that escalate, mostly shouting matches".</p> <p>-One resident reported "[another resident] beat somebody up real bad, hitting them on the head. I actually saw that". The altercation occurred around supper time.</p> <p>-Another named resident was caught eating "cake" and drinking a soft drink of his. The resident stated that he tried to "kick him [the other resident] in the face" but he could not get his leg high enough. He had grabbed the other resident by the hair. Staff followed him and tried to "break things up". He let go of the other resident's hair.</p> <p>Interview with a Personal Care Aide on 11/16/15 at 3:55PM revealed:</p> <p>-The previous night he arrived in the hallway after two named residents had an altercation.</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 220</p> <p>-One of the named residents "sucker punched" the other in the chest who "had wind knocked out".</p> <p>-The one resident who did the punching normally did not behave like this but this resident had coffee and cigarettes taken from him.</p> <p>-Two other named residents had a brief altercation.</p> <p>-"There is nothing we can do, they have rights. We have no right to open a door, no idea what they talk about behind closed doors."</p> <p>Telephone interview on 11/19/15 at 4:06pm with a local law enforcement deputy revealed:</p> <p>-He had been working as a deputy for 12 years and had responded to calls at the facility "since day one".</p> <p>-Most of the 911 calls were for fighting and residents walking away from the facility, "they walk away a lot".</p> <p>-The staff are just there, they are not much of a help.</p> <p>-Residents who are out of control usually are involuntarily committed to a local hospital by the crisis response team.</p> <p>-"You name it, residents will fight over it."</p> <p>-About a month ago two male residents were fighting over the same female resident. The Magistrate won't allow residents to press charges against another resident; they have to call the crisis response team.</p> <p>Telephone interview on 11/19/15 at 4:17pm with a second local law enforcement deputy revealed:</p> <p>-He had responded multiple times to calls at the facility.</p> <p>-Although it had seemed he had responded to calls at the facility "every day," there had not been any calls from the facility the "past two weeks".</p> <p>-"Personally, they don't have a good hold on their</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 221</p> <p>people (residents). We have to do their (staff) job all the time." -He did not believe staff ran the facility correctly . -He knew of other residential facilities in the county, "this place is the only place we get called to".</p> <p>Telephone interview on 11/20/15 at 1:11pm with a third local law enforcement deputy revealed: -The number of calls from the facility was "almost ridiculous". -Staff have been told to call 911 before calling their supervisor for residents with aggressive behaviors. -When there were resident to resident assaults staff would look to involuntarily commit a resident. -Local law enforcement transported residents to the magistrate's office for an involuntary commitment. The behavior described by the facility staff did not always match the residents' behavior, the aggressive or out of control behavior was not being seen by the deputy officer.</p> <p>Interview on 11/17/15 at 2:52pm with the Resident Care Coordinator (RCC) revealed: -If residents were engaged in inappropriate behaviors like screaming and fighting, they were redirected if possible. -If residents were fighting, staff would call 911 if they were unable to stop the fighting, which they were told by one mental health service to do as there was a "faster response".</p> <p>Interview on 11/17/15 at 2:50pm with the Operations Manager revealed: -How the facility responded to an altercation depended on situation. -If just verbal then staff tried to redirect residents without any other interventions, "I would try to</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 222</p> <p>intervene when possible".</p> <p>-If psych(iatric) issues, then (staff) would call mobile crisis.</p> <p>-If violent then we call law enforcement.</p> <p>-We would also notify the provider to come out to do an assessment. I can't do assessments.</p> <p>-We tried to look at how to prevent the behaviors or what is causing them. Is there a staff person upsetting the resident? Is another resident upsetting them? Is something bothering them? I tried to figure out what is going on with them by talking to them. Is this (behavior) out of the norm for the resident, if so then we send them to the ER.</p> <p>-When we called the law enforcement when there is a problem, they would tell us to call mobile crisis, it's a psych(iatric) issue. Mobile crisis would tell us to call law enforcement, it's a criminal law issue.</p> <p>Observation during interview on 11/17/15 at 3:30pm with the Operations Manager revealed:</p> <p>-Resident #18 and another resident began yelling at each other outside of the Operations Manager's window. They were cursing at one another and yelling, "get out of my face and leave me the (expletive word), alone. If you don't get away from me, I'm going to knock your (expletive word) head off".</p> <p>-Upon return the Operations Manager stated, "the other resident got in Resident #18's space and was asking for a cigarette. We redirected both residents and calmed them down".</p> <p>Second interview on 11/19/15 at 9:55am with the Operations Manager revealed:</p> <p>-Physical altercations between residents tended to happen at the end of the month when residents are running out of money and cigarettes, their agitation increases.</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 223</p> <p>-When people are in a common area together there is more of an opportunity for things to happen.</p> <p>B. Based on observations, record reviews and interviews the facility failed to assure residents deemed incompetent and engaging sexual activity were doing so without consent and that appropriate education and safe sex practices were addressed with the residents which resulted in a resident becoming pregnant.</p> <p>Interviews with staff and residents at various times and dates during the survey revealed:</p> <p>-Facility does not have a policy or procedure to ensure that residents are competent to make decisions regarding engaging in sexual activity, especially those involving residents who have been adjudicated incompetent; that appropriate responsible parties and health care providers were notified of residents sexual activity; and that appropriate education and safe sex practices were facilitated.</p> <p>-6 residents were observed by either staff or residents to have sexual encounters in facility (common bathroom or in their rooms).</p> <p>-3 of 6 residents admitted to being engaged in sexual encounters and not using protection to prevent the transmission of sexually transmitted disease (STDs) or communicable infection.</p> <p>-None of the residents had ever known condoms to be available at the facility for residents.</p> <p>-Facility staff, (medication aides and personal care aides) were aware of the residents having sexual encounters because they had observed the sex encounter or the resident had told them of the encounter.</p> <p>-Facility staff had identified residents were sexually active, but did not increase supervision.</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D980	<p>Continued From page 224</p> <p>Interview on 11/17/15 at 9:55 am with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -She was aware resident #26 had a boyfriend that his roommate paid to have sex with the resident while the roommate watched. -She had previously offered to take Resident #26 to get condoms, but the resident told her that she was allergic to the latex in the condom. -She did not verify the latex allergy this with the resident's physician. -She was unaware if anyone had given or offered Resident #26 condoms. <p>Interview on 11/17/15 at 2:52 pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -Regarding resident sexual behavior, staff could not tell them they could not engage in sexual activity. -In the facility, none of the residents had acquired immunodeficiency syndrome, one had herpes and "more" had Hepatitis C (these residents were not sexually active). -Behaviors (mental or sexual) were expected to be documented in progress notes, an incident report completed and also "always" noted in shift reports which were reviewed by the RCC, Operations Manager, and Administrator. -Shift notes did not get sent to the mental health provider. -The 15 minute check identified the resident's location, what the resident was doing. -Residents showing behaviors or otherwise needing additional supervision were placed on 15 minute checks and documented on a sheet that was signed off by the supervisor at the end of the shift. <p>Review of 15-minute check sheets for Resident #26 revealed:</p> <ul style="list-style-type: none"> -The resident was on 15 minute checks various 	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 225</p> <p>days in November and October 2015.</p> <ul style="list-style-type: none"> -The 15 minute checks showed no evidence Resident #26 was supervised for sexual activity. <p>Interview on 11/17/15 at 10:58 am with Resident #26's guardian revealed:</p> <ul style="list-style-type: none"> -She was pretty much told by the Operation Manager they can't stop "them," (residents) from doing anything like that. -The facility had never called to inform her they had a concern about Resident #26 being sexually active. -She was not okay with Resident #26 being pregnant. -One staff (Personal Care Aide, who was also pregnant) told her that Resident #26 being pregnant was "the best thing for the resident." -She told the staff that was not okay. -She "placed 80% of Resident #26 being pregnant on the facility." -Resident #26 was not supervised at all, she needed to be checked on a lot more often. -The facility staff was responsible to supervise Resident #26's activity. -The resident did not make good decisions, which was why she was at the facility, she needed watching. -On that date also the OM informed her that Resident #26's boyfriend was paid \$10.00 by his roommate to have sex with her while he (roommate) was present. -Resident #26 needed supervision because the resident does not realize the responsibility of having sex. The resident associates having sex with love. <p>Interview on 11/12/15 at 10:55 pm with the third shift Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> -One morning she saw a couple in bed together, it was Residents #23 and #26. 	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 226</p> <p>-She did not tell the resident to leave the room, and also told the Medication Aide on duty, which was the facility's protocol.</p> <p>Interview on 11/17/15 at 5:10 pm with a second shift Medication Aide revealed: -She was unable to recall Resident #26 being put on 15 minute checks for being promiscuous on her shift. -The facility did not allow residents in each other's rooms after 10:00 pm. -If the residents were observed in sexual activity they were to tell the Medication Aide on duty, because she was the supervisor.</p> <p>Confidential interview with one of Resident #26's previous roommates revealed: -Resident #26 and her current boyfriend were always in the room having sex. -This happened every day. -Staff did not check the room to monitor and ensure Resident #26 and her boyfriend were not having sex in the room.</p> <p>Interview on 11/19/15 at 12:25 pm with a Medication Aide revealed: -There was no system to monitor or supervise residents because she does not see a lot of that on the first shift. -The 15 minute checks will continue until management tells her to discontinue the checks.</p> <p>Interview on 11/19/15 at 12:35 pm with the Resident Care Coordinator (RCC) revealed: -She identified residents were in a relationship when she saw them hanging out together or they verbally told her they are boyfriend/girlfriend. -Residents have not told her they were physically (sexually) active. -There was no way to know if residents are</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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D980	<p>Continued From page 227</p> <p>having sex.</p> <p>-If staff find out resident are sexually active, they should call the guardian.</p> <p>-No staff at the facility had come to her and told they found residents having sex.</p> <p>-Currently, there was no plan in place to protect residents engaged in sexual activity, but one will be put in place.</p> <p>C. Based on observations, record reviews and interviews the facility failed to provide supervision for residents who had a history of smoking in the facility as evidenced by residents smoking in the facility activating fire alarms 18 times in a 6 month period and a resident with a known history of starting fires of setting a fire a resident bathroom.</p> <p>Review of a McDowell County sanitation and building inspection report dated 10/27/15 revealed:</p> <p>-Comment section; Try to limit smoking to designated outdoor smoking areas.</p> <p>-Evidence of residents smoking in restrooms and other areas.</p> <p>Review of McDowell County Sheriff's communications call log revealed a total of 202 calls from 5/2/15 through 11/5/15 (approximately six months) made from Cedarbrook Residential Care Facility to the McDowell County Sheriff's Office included 19 calls made for activation of the fire alarm, several noted the specific reason being smoking inside of the facility in resident rooms and bathrooms.</p> <p>Interviews with residents revealed:</p> <p>-They had seen other residents smoking in the resident bedrooms and bathrooms.</p> <p>-"The staff tells them not to smoke but that's all."</p> <p>-The staff light cigarettes for residents on</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D980	<p>Continued From page 228</p> <p>restrictions but doesn't stay with them. They come back into the building and leave them alone."</p> <p>-Staff were aware of residents smoking in their rooms, because he told them but, there was no way to find out who it was.</p> <p>-A resident said his roommate smoked in the room all the time.</p> <p>-The medication aide and Personal Care Aide told him to tell his roommate not to smoke in the room.</p> <p>Interviews with staff revealed:</p> <p>-When residents are caught smoking they put them on 15 minute checks but, "that's all we can do about it."</p> <p>-"We take their cigarettes and lighters from them. They can only go smoke with supervision every two hours.</p> <p>-The Resident Care Coordinator and the Operations Manager decides when to remove the resident from restrictions.</p> <p>-"Some residents are on indefinite restrictions."</p> <p>-We had a fire in the bathroom from a resident who set towels and linens on fire. He was on smoking restrictions after the fire."</p> <p>-(Resident's name) was caught smoking last night "and we put it in the book and that is all we can do about it".</p> <p>Interview on 11/30/15 at 11:25am with the Operations Manager revealed:</p> <p>-"The physician progress notes document where they (physician) have talked with the resident concerning smoking cessation, but no orders given.</p> <p>-They do have a smoking policy, the residents are supposed to follow.</p> <p>-If the behavior continues then will have to look at discharge.</p>	D980		

Division of Health Service Regulation

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D980	<p>Continued From page 229</p> <ul style="list-style-type: none"> -If someone is on restrictions then the staff will go out to supervise them while smoking. -It depends on the resident and if they need full-time supervision or not. -If not the staff will stay for a little while, then come back in and supervise from the building. -She was not aware staff was leaving residents alone when they were on smoking restrictions, instead of being there to supervise. -She could not remember the last time a resident had been discharged for smoking in the facility." <p>Based on observation, interviews and record reviews, additional non-compliance related to the management of the facility identified during the survey was as follows:</p> <p>A. Based on observations the facility failed to assure the exterior grounds were kept in a clean and orderly condition as evidenced by trash thrown over the fence at the 400 Hall smoking area and around the building. [Refer to Tag 072, 10A NCAC 13F .0305(m) Physical Environment].</p> <p>B. Based on observation, record review and interviews, the facility failed to make repairs to or maintain in clean condition floors, walls, ceilings, doors and light fixtures throughout the facility [Refer to Tag 074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings].</p> <p>C. Based on observation, record reviews and interviews, the facility failed to correct multiple hazards, which include excessive clutter in 1 resident room (Room #200); for not using approved surge protection devices to prevent overloading of electrical outlets and having cracked outlet faceplates for 4 resident rooms (Rooms #105, #208, #303 and #410); for not effectively controlling for cockroaches throughout</p>	D980		

Division of Health Service Regulation

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D980	<p>Continued From page 230</p> <p>the facility; and for not repairing a loose metal baseboard heater cover in 1 resident rooms (room #105). [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (B Violation)].</p> <p>D. Based on observation and interview the facility failed to assure residents' mattresses were clean, in good condition and had clean sheets as evidenced by dirty and ripped mattresses and no sheets on resident beds. [Refer to Tag 087, 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings].</p> <p>E. Based on record review, observation and interview, the facility failed to assure staffing met minimal requirements according to census for 5 of 16 night shifts from October 16, 2015 through October 31, 2015 and in addition, the facility failed to meet the needs of the residents identified in the areas of supervision and resident rights [Refer to Tag 188, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)].</p> <p>F. Based on observation and interview, the facility failed to assure any assigned housekeeping tasks (facility and resident laundry) by aides were limited to occasional, non-routine tasks between 7:00 am and 9:00 pm [Refer to Tag 206, 10A NCAC 13F .0604(2-B) Personal Care and Other Staffing (B Violation)].</p> <p>G. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 of 6 sampled residents as evidenced by one resident, who was deemed incompetent, known by staff to be sexually active and at a higher risk of pregnancy due to antibiotic therapy, and the</p>	D980		

Division of Health Service Regulation

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D980	<p>Continued From page 231</p> <p>resident became pregnant (#26); one resident who was a known smoker and had a known history of starting fires resulting in a fire at the facility (#2) and for various residents with history of repeated smoking in the facility. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (A1 Violation)].</p> <p>H. Based on observation, record review and interviews, the facility failed to assure referral and/or physician notification for 1 of 1 sampled resident who was deemed incompetent, known by staff to be sexually active, and at a higher risk of pregnancy due to antibiotic therapy and resident became pregnant (#26); 1 of 1 sampled resident with unabated hoarding (#21); 1 of 9 sampled residents regarding refusing blood pressure checks and fingerstick blood sugar checks (#17); and, 1 of 9 sampled residents refusing medications (#22). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].</p> <p>I. Based on observation, interview and record review, the facility failed to ensure residents received a complete set of flatware that included a knife and fork in order for residents to eat their meals without having to wait for assistance from staff to cut up food or having to use their hands to eat food that could be not be cut or eaten with only a spoon. [Refer to Tag 287, 10A NCAC 13F .0904(b)(2) Nutrition and Food Service].</p> <p>J. Based on interview, observation and record review, the facility failed to assure at least 14 hours of planned group activities were provided each week for the residents that promoted socialization, physical interaction, group accomplishment, and learning of new skills. [Refer to Tag 317, 10A NCAC 13F .0905(d)]</p>	D980		

Division of Health Service Regulation

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D980	<p>Continued From page 232</p> <p>Activities (Type B Violation)].</p> <p>K. Based on observation, interview, and record review, the facility failed to protect residents from abuse, neglect, and exploitation by failing to protect residents from physical assaults resulting in injury to residents; by admitting residents with violent, aggressive, and dangerous behaviors; by failing to discharge residents with aggressive, and dangerous behaviors; by implementing a resident work program that was used as a tool for discipline and coercion and for which residents were not given fair or equitable compensation for work completed that benefited the facility; by failing to properly maintain and repair durable medical equipment for four residents (#7, #8, #19 and #20); by failing to manage a resident's hoarding behavior which resulted in a safety hazard and cockroach infestation in the resident's room; and neglecting 2 of 2 residents with promiscuous activity. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (A1 Violation)].</p> <p>L. Based on observation, interview, and record review, the facility failed to assure contact with the resident's physician for clarification of medication orders for 2 of 9 residents sampled; one resident with an order for Clonazepam not included on readmission from a local hospital (Resident #13); and changes in dosage for clozapine (Resident #25) and sliding scale insulin parameters from a hospital discharge summary for one resident (Resident #25). [Refer to Tag 344, 10A NCAC 13F .1002(a) Medication Orders].</p> <p>M. Based on observation, interview and record review the facility failed to assure sliding scale insulin was administered for Finger Stick Blood Sugars (FSBS) as ordered for 1 of 1 sampled resident (#6). [Refer to Tag 358, 10A NCAC 13F</p>	D980		

Division of Health Service Regulation

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D980	<p>Continued From page 233</p> <p>.1004(a) Medication Administration].</p> <p>N. Based on observation, interview and record review, the facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy by routinely crushing controlled drug medications for all residents when not indicated in all residents' individualized plan of care; by failing to consider the individual needs and privacy of each resident during medication administration by requiring residents to line up in the hallway to receive medications; by failing to administer injectable medications discreetly and in private; failing to respect and ensure the dignity of residents by dressing residents in ill-fitting and tattered clothing that did not belong to the residents; by failing to provide clean sheets for mattresses; and by failing to provide a complete set of flatware to each resident at meal times. [Refer to Tag 911, 10A NCAC 13F G.S. § 131D-21(1) Declaration of Resident's Rights (Type A2 Violation)].</p> <p>_____</p> <p>A plan of protection was submitted by the facility on 11/19/15 that included management will ensure that the plan of protection submitted throughout this survey process will be followed and management will work on reviewing current processes to determine if new or revised processes need to be implemented.</p> <p>_____</p> <p>The violations identified resulted in serious neglect by the facility as evidenced by the failure of the administrator to recognize and address noncompliance of multiple rule areas that directly impact the health, safety and welfare of residents and violations of resident rights to ensure appropriate care and services provided, recognition of individuality of residents, right to</p>	D980		

Division of Health Service Regulation

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D980	Continued From page 234 privacy, consideration and respect and to ensure the safety of residents and residents free of abuse, neglect and exploitation. DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2015.	D980		