DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G237	A. BUILDING ______ B. WING ______	02/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK GROUP HOME	301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791

(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) COMPLETION DATE
W 000	INITIAL COMMENTS Complaint Intake #: NC00147999	W 000		
W 136	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(11) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, review of records and interview, the facility failed to have an effective system to assure 3 of 3 sampled clients (#1, #4 and #5) were able to participate in scheduled community outings. The finding is: Observations in the group home during the 2/5-6/2019 survey revealed no observation of scheduled activities for the group home. Interview with the home manager (HM) on 2/5/19 revealed the group home had an activities calendar although she was unsure where copies of the calendar were at the time of the interview. Further interview with the HM on 2/5/19 revealed community outings are at times rescheduled due to staff shortage. The HM verified the group home to have three open positions at the time of the current survey. It should be noted on 2/6/19 the HM provided the surveyor with activity calendars for November 2018, December 2018 and January 2019. Review of records for client's #1, #4 and #5 on 2/6/19 revealed progress notes written by the qualified intellectual disabilities professional (QIDP) throughout the review year with no	W 136	The Home Manager will develop a monthly Activity Calendars and submit to the QIDP for approval. The calendars willl include at the minimum 2 group outings and 1 personal outing per month. A copy of the Activity Calendar will also be given to the business manager to ensure funds will be available. Documentation of all outings will be maintained by the Home Manager and monitored by the QIDP for compliance through the Community Options Tracking Log. The administrator will monitor during Monday meetings to ensure outings are occurring as scheduled. In the future, the QIDP will assure effective systems are in place to provide the clients right to participate in the community outings. RECEIVED FEB 28 2019 DHSR NH L & C Black Mountain / WRO	4-7-2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/25/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 136	Continued From page 1 indication of any community outings for any client. Review of financial statements provided by the facility for client #1 revealed the client to have funds withdrawn during the review year for a client outing on 3/6/18, 4/25/18, and 7/9/18 only. Additional review of client #1's financial statement revealed the client to have pocket money withdrawn on 6/7/18, 7/31/18 and 8/22/18. Review of client #4's financial statement for the review year revealed the client to have funds withdrawn for a client outing on 3/6/18 only. Review of client #5's financial statement for the review year revealed the client to have no funds withdrawn for the purpose of a client outing. Interview with the facility administrator on 2/6/19 verified individual client outings should be reflective in documentation and financial statements. Further interview with the facility administrator revealed he was unsure why clients had not been going on community outings although the facility recently has been short of staff. Subsequent interview with the facility administrator revealed an in-service on 1/15/19 had been provided to staff regarding outings and all clients should have the opportunity to participate in 2 out to eat outings each month, paid for by the facility. Interview with the facility HM on 2/6/19 revealed client's in the group home had been on outings during the review year. Additional interview with the HM on 2/6/19 verified documentation was not available to support details of community outings such as when outings occurred or which client's went on the outing.	W 136		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)	W 153		

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W 153	Continued From page 2 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an injury of unknown source was reported immediately to the administrator for 1 of 3 sampled clients (#5). The finding is: Review of facility incident reports for the past 3 months, conducted on 2/5/19, revealed a report of an injury of unknown origin for client #5 dated 1/13/19. Further review of the 1/13/19 incident report for client #5 revealed documentation that client #5 was noted to have a "decent sized" bruise on his left cheek, and further stated "staff is not sure how or why". Continued review of the 1/13/19 incident report revealed documentation the injury may have occurred in client #5's bedroom and could have resulted from behaviors on the day prior to the report. This report indicated the group home manager and the nurse were notified of the bruise to client #5's left cheek on 1/13/19. Nursing notation on the 1/13/19 report, which was dated 1/17/19, indicated bruising was noted at the left eye and cheek, and stated client #5 was sent for an x-ray with no fracture noted. On-going review of the 1/13/19 incident report for client #5 revealed signatures dated 1/18/19 by the Facility administrator and the QIDP. Interview conducted with the nurse on 2/6/19 revealed the nurse had been notified of the bruise	W 153	The QIDP will in-service all the staff on the importance of notifying the QIDP and Administrator of any injuries of unknown origin. The Administrator will in-service nursing on the reporting requirements for injuries of unknown origin. The Administrator will monitor Incident Reports as they occur to ensure the protocol for notification of injuries of unknown origin occurs. In the future the QIDP will ensure staff are trained to report all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown origin are reported immediately.	4-7-2019

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W 153	Continued From page 3 on client #5's left cheek on 1/13/19. This interview further verified the nurse reported the bruise to the physician and obtained an order for an x-ray on 1/14/19. Interviews with the facility administrator and the QIDP, conducted on 2/6/19, revealed the bruise of unknown origin to client #5's left cheek had come to the attention of both the administrator and the QIDP on 1/18/19, when they both had reviewed and signed the report. This interview further verified staff should have reported this incident to the administrator when the bruise was noted. Therefore, there was a delay of 5 days after the injury of unknown origin was observed by staff before it was reported to the administrator.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records and staff interview, the facility failed to assure an injury of unknown origin was thoroughly investigated for 1 of 3 sampled clients (#5). The finding is: Review of facility incident reports for the past 3 months, conducted on 2/5/19, revealed a report of an injury of unknown origin for client #5 dated 1/13/19. Further review of the 1/13/19 incident report for client #5 revealed documentation that client #5 was noted to have a "decent sized" bruise on his left cheek, and further stated "staff is not sure how or why". Continued review of the	W 154	The Regional Vice President will in-service the Administrator and QIDP on investigating injuries of unknown origin thoroughly. The Administrator will monitor Incident Reports as they occur to ensure the protocol for notification of injuries of unknown origin occurs and all instances are thoroughly investigated. In the future the Administrator will ensure all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown origin are investigated thoroughly.	4-7-2019

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W 154	Continued From page 4 1/13/19 incident report revealed documentation the injury may have occurred in client #5's bedroom and could have resulted from behaviors on the day prior to the report. This report indicated the group home manager and the nurse were notified immediately when the bruise was noted by staff. Nursing notation on the 1/13/19 report indicated bruising was noted at the left eye and cheek, and stated client #5 was sent for an x-ray with no fracture noted. This nurses notation was signed by the nurse with a date of 1/17/19. On-going review of the 1/13/19 incident report for client #5 revealed signatures dated 1/18/19 by the Facility administrator and the QIDP. Review of the record for client #5 revealed an x-ray report dated 1/14/19 indicating no orbital fracture was noted. Interview conducted with the nurse on 2/6/19 revealed the nurse had been notified of the bruise on client #5's left cheek on 1/13/19. This interview further verified the nurse reported the bruise to the physician and obtained an order for an x-ray on 1/14/19. Interviews with the facility administrator and the QIDP on 2/6/19 verified they were both notified of the bruise of unknown origin to client #5's left cheek on 1/18/19, however, no investigation had been initiated regarding this injury.	W 154		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present	W 186		

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W 186	Continued From page 5 on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, interview and record review the facility failed to assure sufficient direct care staff were available to meet client needs. The finding is: Observation on 2/5/19 at the vocational site for all clients in the group home revealed all clients to be in the community participating in volunteer opportunities with meals on wheels. Interview with the facility administrator on 1/5/19 verified all clients were in the community. Review of records for client #1 on 2/5/19 revealed a vocational objective to empty trash implemented 4/17/17. Review of data relative to client #1's objective to empty trash revealed from 9/2018-11/30/18 the objective was suspended due to no attendance. Additional documentation of client #1's empty trash objective revealed on 1/28/19 the objective was reinstated. Review of client #4's record on 2/5/19 revealed a vocational objective to sort objects by shape implemented 9/19/17. Review of data relative to client #4's objective to sort objects by shape revealed from 9/2018-11/30/18 the objective was suspended due to no attendance. Additional documentation of client #4's objective to sort objects by shape revealed on 1/1/19 the objective was reinstated. Review of a vocational center census on 2/6/19 revealed attendance for all clients at the vocational center over the last quarter of the review year (10/2018-1/2019). Review of the vocational center census revealed in 10/2018,	W 186	The allocated hours for the home were completed by the Regional Vice President and Administrator. The Administrator will in-service the QIDP and Home Manager on the staffing patterns and ratio of the home. The Administrator will monitor hours daily via the Daily Hours Report to ensure staffing patterns and ratios are being provided. In the future the Administrator will ensure staffing patterns are provided and followed to meet client needs in accordance with their Person Centered Plans.	4-7-2019

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W 186	Continued From page 6 Client #1 attended the vocational center 6 days, client #2 attended 7 days, client #3 attended 10 days, client #4 attended 11 days and clients #5 and #6 attended 9 days. Attendance review of 11/2018 revealed client #1 to attend 8 days, clients #2 and #4 to attend 5 days, clients #3 and #5 to attend 7 days and client #6 to attend 4 days. Attendance review of 12/2018 revealed clients #1, #3 and #4 to attend 3 days and clients #2, #5 and #6 to attend 2 days. Attendance review of 1/2019 revealed clients #1, #4 and #5 to attend 12 days, clients #2 and #3 to attend 10 days and client #6 to attend 11 days. Review of financial statements provided by the facility for client #1 on 2/6/19 revealed the client to have funds withdrawn during the review year for a client outing on 3/6/18, 4/25/18, and 7/9/18 only. Additional review of client #1's financial statement revealed the client to have pocket money withdrawn on 6/7/18, 7/31/18 and 8/22/18. Review of client #4's financial statement for the review year revealed the client to have funds withdrawn for a client outing on 3/6/18 only. Review of client #5's financial statement for the review year revealed the client to have no funds withdrawn for the purpose of a client outing. Interview with the facility administrator on 2/6/19 revealed clients had not been attending the vocational program as scheduled due to staff shortage. The facility administrator further indicated a client in the group home has behavioral issues that prevents the client from being transported at times. Further interview with the facility administrator revealed when the group home has only two staff, if one client is unable to be transported all clients must stay at the group home to ensure proper staff ratio.	W 186		

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W 186	Continued From page 7 Continued interview with the facility administrator on 2/6/19 verified individual client outings should be reflective in documentation and financial statements. Further interview with the facility administrator revealed he was unsure why client's had not been going on community outings although the facility recently has been short of staff. Interview with the facility home manager (HM) on 2/5/19 verified staff shortage in the facility with 3 open positions. Additional interview with the HM on 2/6/19 verified documentation was not available to support details of community outings over the review year such as when outings occurred or which client's went on the outing.	W 186		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide needed interventions in sufficient number and frequency to support the achievement of communication and behavioral objectives identified in the individual program plan (IPP) for 1 of 3 sampled clients (#5). The findings are:	W 249	A team meeting will be held to discuss a TEACCH and communication program for client #5. The QIDP will revise the Person Centered Plan to reflect the team meeting. The Behavior Analyst and Habilitation Specialist will in-service staff on the results of the team meeting. The clinical team will monitor 2x a week for 1 month and then on a routine basis through Interaction Assessments and observations to ensure staff are implementing interventions described in the team meeting. In the future the QIDP will ensure interventions and services in sufficient number and frequency are implemented to support achievement of the objectives identified in the Person Centered Plan.	4-7-2019

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W 249	Continued From page 8	W 249		

Continued From page 8

A. The facility failed to provide needed interventions to support the achievement of a behavioral objective identified in the IPP for client #5.

Observations conducted in the group home throughout the 2/5/19 - 2/6/19 survey revealed client #5 was verbally prompted by staff to participate in leisure activities, meal preparation, setting table, eating meals, using bathroom, washing hands and medication administration among other activities. No use of a TEACCH schedule was observed at any time during the 2/5/19-2/6/19 survey.

Review of the record for client #5, conducted on 2/5/19 and 2/6/19 revealed an IPP dated 1/16/19. Review of the 1/16/19 IPP revealed a Psychology Evaluation dated 1/14/19 which stated staff should encourage the use of a picture schedule to ensure a stable and predictable routine for client #5. Further review of the IPP revealed a behavior support plan (BSP) dated 2/1/19 which documented targeted behaviors included repetitive requests, agitation, difficulty transitioning, self injury, restlessness, aggression and disrupted sleep. Continued review of the BSP revealed prevention strategies/interventions for transition difficulties, agitation/aggression, repetitive requests and disrupted sleep should include the use of a TEACCH schedule with picture icons.

Interview conducted on 2/6/19 with the qualified intellectual disabilities professional (QIDP)verified a TEACCH schedule should be utilized for client #5 as documented in the 1/16/19 IPP. Interview with the group home manager conducted on

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W 249	Continued From page 9 2/6/19 verified staff are not currently utilizing a TEACCH schedule in the group home for client #5. B. The facility failed to provide needed interventions to support the achievement of a communication objective identified in the IPP for client #5. Observations conducted in the group home throughout the 2/5/19-2/6/19 survey revealed client #5 was verbally prompted by staff to participate in activities including using the bathroom and medication administration among others. No use of communication pictures or cards was observed during the survey. Review of the record for client #5, conducted on 2/5/19 and 2/6/19 revealed an IPP dated 1/16/19. Review of the 1/16/19 IPP revealed a communication objective with an implementation date of 1/18/18 stating client #5 would select appropriate communication cards with 90% accuracy for two consecutive review periods. Continued review of the IPP for client #5 revealed a Communication Evaluation dated 12/20/17 recommending client #5 have a communication system available to him as he moves between settings so he may refer to it when having difficulty communicating via speech. Further review of the record for client #5 revealed a mini-team report dated 1/9/18 documenting the interdisciplinary team accepted the recommendations of the 12/20/17 Communication Evaluation, and further documented the habilitation specialist would design a communication program to be available as client #5 moves between settings.	W 249		

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W 249	Continued From page 10 Interview conducted on 2/6/19 with the habilitation specialist verified staff should assist client #5 in the use of picture cards indicating medication administration, bathroom, food and drink as indicated in the communication objective implemented on 1/18/18. Interview conducted with the QIDP verified staff should utilize client #5's expressive communication picture cards during all appropriate opportunities.	W 249		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, nursing services failed to provide staff training relative to thickening of liquids, and failed to assure physician-ordered laboratory studies were completed in a timely manner for 1 of 3 sampled clients (#5). The findings are: A. Observations conducted on 2/5/19 during the supper meal revealed client #5 was assisted by staff to pour beverages for the meal including water and tea without measuring either beverage. Continued observations revealed client #5 was prompted by staff to take a drink of his beverage which he did, and subsequently began to cough. Staff was then noted to go into the kitchen and retrieve a container labeled as Thick-It and place two scoops of Thick-It powder in each cup of beverage sitting in front of client #5. Client #5 was then observed to immediately begin to drink the tea, with a lump of powder sitting on top of the liquid. Staff was then observed to stop client #5	W 331	Nursing will in-service staff on client #5's order for nectar-thick liquids and the use of Thick-it. The clinical team will monitor 2x a week for 1 month and then on a routine basis through Mealtime Assessments to ensure Thick-it is being implemented as prescribed. In the future nursing will ensure staff are trained relative to Thick-it to thicken liquids.	4-7-2019

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W 331	Continued From page 11 from drinking and assist him to stir the Thick-It powder into each cup, which he resumed drinking immediately. Observations conducted on 2/6/19 during the breakfast meal revealed client #5 sat at the dining table with two empty cups at his place setting. Staff was then observed to assist client #5 to pour milk into one cup and water into the other without measuring either beverage. Client #5 was then observed to begin to drink his beverages at which time the surveyor asked staff if client #5 should receive thickened liquids. Staff #1 stated client #5 did not receive thickened liquids, Staff #2 stated client #5 should receive honey-thick liquids. On-going observation following these staff interviews revealed staff #2 to add two scoops of Thick-It powder to each cup of liquid and assist client #5 to stir them. Client #5 then began to drink the milk immediately. Review of the directions on the container of Thick-It currently in use for client #5, conducted on 2/6/19, revealed the following measurements in order to achieve a nectar-thick consistency per 4 fluid ounces of liquid: Milk 4 to 4-1/2 teaspoons, water 3-1/2 to 4 teaspoons and tea 3-1/2 to 4 teaspoons. Further review of the instructions for the use of Thick-It powder revealed the powder should be stirred briskly into the liquid until the powder has dissolved, allowing water and tea to stand 30 seconds before consuming and milk to stand 5 - 10 minutes before consuming. Review of the record for client #5, conducted on 2/6/19, revealed a physician's order dated 1/28/19 prescribing a regular chopped diet with nectar-thick liquids, as recommended on a	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G237	A. BUILDING ______ B. WING ______	02/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK GROUP HOME	301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791

(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) COMPLETION DATE
W 331	Continued From page 12 Speech Language Professional (SLP) consultation dated 12/20/17. Interview conducted with the nurse on 2/6/19 revealed the proper thickening of liquids for client #5 is nectar thick. This interview further verified staff should use the directions on the container of Thick-It and measure the amount of liquid as well as the amount of thickener, stir and wait the directed amount of time before serving the liquid to client #5.	W 331		
	B. Review of the record for client #5, conducted on 2/6/19, revealed a quarterly drug review dated 10/4/18 containing a recommendation signed by the pharmacist recommending an ammonia level be drawn for client #5 to monitor for possible side effects of prescribed Depakote. Continued review of the record for client #5 revealed the physician agreed to this recommendation and ordered the ammonia level to be obtained during the next scheduled blood draw. Continued review of the record for client #5 revealed a blood specimen was sent to the laboratory on 11/26/18. The results of the 11/26/18 lab studies did not include documentation of an ammonia level, as verified by interview with the nurse on 2/6/19. This interview with the nurse further indicated the nurse had inadvertently failed to place the ammonia level on the lab request form on 11/26/18.		The Regional RN will in-service the LPN's on obtaining lab's as prescribed by the physician. The QIDP will monitor through quarterly QIDP notes and routine Core Team Meetings to ensure labs are completed as prescribed. In the future nursing will ensured physician ordered laboratory studies are completed in a timely manner.	4-7-2019