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 _____	C 10/30/2019

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	W 000		
W 153	Intake #NC00157837 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(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 allegations of abuse were reported immediately to the administrator for 3 of 6 clients (#3, #5 and #6) in the group home. The finding is: Review of facility incident reports for the past 3 months, conducted on 10/30/19, revealed during third shift on 7/10/19 at 6:45 AM client #5 had a fall with bruising to both eyes and during third shift on 10/25/19 at 6:35 AM client #6 had a fall that resulted in a broken arm. Additional review of incident reports revealed on 10/1/19 client #3 obtained a bruise to the right arm due to peer on peer aggression . Interview with staff A on 10/30/19 revealed the staff to work second shift in the group home. Continued interview with staff A revealed concerns with injuries to clients resulting on third shift. Staff A referenced incidents on 7/10/19 of client #5, 10/1/19 of client #3 and 10/25/19 of client #6. Staff A further reported he had heard from other staff about concerns with client #3	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 153	Continued From page 1	W 153		

having bruising that was attributed to third shift staff and covered up by the home manager (HM). Subsequent interview with staff A revealed he had observed third shift staff talk harshly and make clients return to their rooms if they came out of their rooms. Additional interview with staff A revealed concerns of abuse by third shift staff had not been reported as staff, including staff A, were afraid of retaliation by the HM. Staff A revealed with regard to the most recent injury in the group home of client #6 on 10/25/19, the HM informed staff "Do not talk about it, we can not afford to lose anyone else."

Interview with staff B on 10/30/19 revealed the staff to work first shift and some second shifts. Continued interview with staff B revealed the staff to report witnessing physical and verbal abuse by the HM towards client #5 by withholding food when the client was having behaviors stating "You can eat when your behaving." Staff B further reported observing the HM to slap the hand of client #5 when the client grabbed someone's drink to make the client put the drink down. Staff B further reported observing verbal abuse by the HM towards clients, making the statements "I hate you" and "Why are you being such a pain in my ass today?" Staff B additionally reported client #3 had reported to her that "[third shift staff] hurt me" and showed staff bruising on his right arm. Staff B subsequently revealed after client #3 made the allegation the HM verbally redirected the client to indicate client #4 had caused the bruising on client #3's arm. Staff B revealed the HM then informed her if client #3 verbally reports staff caused the bruising on his arm to redirect the client to acknowledge client #4 caused the bruising. Staff B further reported the internal incident report filed on 10/1/19 by the HM

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W 153	Continued From page 2	W 153		

regarding client #3's arm bruising was not true as the HM reported the incident happened on the van in the afternoon and the bruising was already present the morning of 10/1/19. Interview with staff B further revealed the staff to ask the HM to remove her name from the incident report to which the HM dismissed staff's request. Staff B reported during the investigation interview " I did not witness the event on the van and its not what happened". Staff B subsequently reported the HM made statements to staff regarding the incident on 10/25/19 of client #6 that "All our stories need to match" and "Nobody needs to talk to anybody". Staff B confirmed she had not reported allegations of abuse or mistreatment due to fear of the HM.

A review of in-service trainings relative to reporting allegations of abuse and neglect revealed staff including the HM, staff A and B were trained in 2019. The HM was provided training on 3/5/2019, Staff A on 10/1/19 and staff B on 3/14/19. Review of in-service content relative to trainings on reporting abuse and neglect revealed injuries of unknown origin should be reported immediately to the qualified professional (QP) or administrator as well as allegations of mistreatment, neglect or abuse. A review of internal policy regarding abuse, neglect and exploitation revealed all staff are required to immediately report acts of abuse, neglect or exploitation to the case responsible person or the administrator.

Interview with the facility habilitation specialist on 10/30/19 verified the facility HM was currently suspended due to a current internal investigation involving the 10/25/19 incident of client #6. Further interview with the habilitation specialist

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W 153	Continued From page 3 and administration staff verified the current third shift staff in the facility had also not been back to work since the 10/25/19 incident of client #6 due to vacation leave and the internal investigation. Further interview with the habilitation specialist and administration verified allegations of abuse and mistreatment had not been reported by facility staff relative to client #5's mistreatment by the HM at meals or with drinks, or client #3's alleged abuse by third shift staff resulting in right arm bruising. Interview with the habilitation specialist and administration confirmed all allegations of abuse or mistreatment should be reported immediately to the QP or administrator.	W 153		