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 _____	11/09/2021

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

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E 007	EP Program Patient Population CFR(s): 483.475(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) contained information specific to the	E 007		

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

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E 007	Continued From page 1 needs of 3 of 6 clients (#2, #4 and #6) in the group home. The finding is: Review of the facility EPP on 11/8/21 revealed the plan to contain current client specific information for clients #1, #3 and #5. Continued review of the EPP revealed the plan to contain client information for a client that was discharged from the facility in 2020. Further review of the EPP revealed no evidence of client specific information for clients #2, #4 and #6 such as diagnosis, behavior plans, communication deficits or other needs. Interview with the qualified intellectual disabilities professional (QIDP) revealed the EPP should not contain information relative to a discharged client. Continued interview with the QIDP revealed the EPP is reviewed periodically and kept at the group home. Further interview with the QIDP confirmed the EPP should contain up to date client specific information for each client in the home.	E 007		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure coordination to address timely meal needs for 4 of 6 clients (#1, #2, #4 and #6). The finding is: Observation at the facility administration office on 11/8/21 at 11:00 AM revealed clients #1, #2, #4	W 104		

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W 104	Continued From page 2	W 104		

and #6 to have been transported to the office building for current day vocational activity. Continued observation at 11:30 AM revealed clients #1, #2, #4 and #6 to engage in various classroom activities to include different program activities, games and social interaction with staff. Further observation at 12:00 PM revealed clients #1, #2, #4 and #6 to prepare for lunch with putting away activity materials and to be verbally told by staff "You're going to eat soon."

Subsequent observation at 12:30 PM revealed clients #1, #2, #4 and #6 to continue to sit in a classroom and to wait for their lunch meal. Observation of client #6 at 12:30 PM revealed the client to repeatedly verbalize to the surveyor that he was hungry. Observation at 1:20 PM revealed the group home manager to return from the grocery store with lunch items for clients #1, #2, #4 and #6 and each client to be served food items that included a sandwich in accordance with their prescribed diet.

Interview with staff A on 11/8/21 at 12:00 PM revealed clients #1, #2, #4 and #6 usually eat lunch at 12 PM. Interview with the qualified intellectual disabilities professional (QIDP) on 11/8/21 at 12:30 PM revealed he had not realized clients #1, #2, #4 and #6 had not had lunch and he was not sure what was going on as he thought pizza had been ordered for the clients. Interview with the QIDP at 12:40 PM revealed the group home manager had been sent to the grocery store to pick up lunch for clients #1, #2, #4 and #6 and there had been an unnecessary delay in ensuring a lunch meal for the clients due to a lack of coordination and communication amongst staff and leadership.

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W 104	Continued From page 3 Further interview with the QIDP on 11/8/21 verified there are always snacks kept at the vocational site although no client was offered a snack despite a delay in providing clients #1, #2, #4 and #6 their lunch meal. Additional interview with the QIDP verified clients could have also brought a packed lunch from the group home to the vocational site which could have also prevented the delay with the lunch meal. Interview with all oversight and management staff on 11/8/21 verified there had been poor coordination and planning with having clients #1, #2, #4 and #6 at the vocational site on 11/8/21 and with ensuring timely meal needs were met.	W 104		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, review of records and interview, the person centered plan (PCP) failed to have sufficient training to meet identified client needs for 1 of 3 sampled clients (#2). The finding is: Observation in the group home on 11/9/21 of the facility's emergency food supply revealed the supply to consist of several can goods and the container used to store the supply to be near empty. Interview with the group home manager on 11/9/21 revealed he had not realized the emergency supply was so low and food items come up missing due to the hoarding behavior of client #2.	W 227		

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W 227	Continued From page 4 Review of records for client #2 on 11/9/21 revealed a PCP dated 3/10/21. Review of the PCP for client #2 revealed a behavior support program (BSP) dated 2/15/21 with an addendum dated 3/30/21. Review of client #2's BSP revealed target behaviors of uncooperation, signs of agitation, verbal and physical aggression, AWOL and unusual thoughts. Review of the 3/2021 BSP addendum revealed the addition of disrupted sleep to the BSP. Further review of the BSP revealed no identified behavior of hoarding food or food stealing. Review of mini-team notes dated 3/25/21 revealed: Client #2 is stealing food. Constantly wanting to eat/drink. The client is on a relatively large dose of Zyprexa (40mg). Team is to assess if med change would be appropriate. Staff will be in-serviced to address zones to maintain adequate supervision. Review of mini-team meetings for client #2 revealed on 10/4/21 meeting notes to indicate: Client #2 is sneaking food into his bedroom. Staff will check client #2's room one time per shift for food. Psychologist is to write an addendum to address health and safety issue of food in client #2's room. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed he had only recently become the QIDP for the group home. Continued interview with the QIDP verified food stealing should be addressed in client #2's BSP as identified with the 3/25/21 and 10/4/21 mini-teams.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 5 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 observations, record review and interviews, the facility failed to ensure 2 of 3 sampled clients (#2 and #6) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The findings are: A. The team failed to ensure a training objective to address oral hygiene was implemented as prescribed for client #2. For example: Observation in the group home at 8:30 AM on 11/9/21 revealed client #2 to participate in the breakfast meal. Continued observation revealed client #2 to participate in various activities after the breakfast meal such as sweeping the dining area and leisure activity with watching television in the living room. Further observation at 9:05 AM revealed client #2 to load the facility van for transport to the day program. At no time after the breakfast meal were staff observed to prompt client #2 to brush his teeth or complete any hygiene activity. Review of records for client #2 on 11/9/21 revealed a PCP dated 3/10/21. Review of client	W 249		

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W 249	Continued From page 6 #2's PCP revealed a training objective to address toothbrushing. Review of the toothbrushing program for client #2 revealed client #2 will brush his teeth twice daily with 95% accuracy for three progress periods. Continued review of client #2's toothbrushing program revealed after breakfast, please ask, "Did you brush your teeth this morning?" If client #2 responds with "yes" record a (+), if he responds with "no" ask him to do so and record a (-). Interview with the qualified intellectual disabilities professional on 11/9/21 verified all programs should be implemented as prescribed and client #2 should have been prompted to brush his teeth before leaving for the day program. B. The team failed to ensure a training objective to address oral hygiene was implemented as prescribed for client #6. For example: Observation in the group home at 8:30 AM on 11/9/21 revealed client #6 to participate in the breakfast meal. Continued observation revealed client #6 to return to his room after the breakfast meal and go back to bed. Further observation at 9:00 AM revealed all clients to load onto the van to attend the day program, except for client #6 who remained in his room. Additional observation at 9:02 AM revealed the house manager (HM) to enter client #6's bedroom and prompt the client to get up as it was time to leave for the day program. At no time after the breakfast meal were staff observed to prompt client #6 to brush his teeth or complete any hygiene activity. Review of client #6's record revealed a PCP dated 1/6/21. Review of client #6's PCP revealed a training objective dated 11/4/21 that client #6	W 249		

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W 249	Continued From page 7 "will participate in oral hygiene with staff assistance with 95% accuracy for 3 consecutive progress periods." Further review of the training objective revealed procedures that "staff will assist with brushing teeth in the morning and night, document once daily. Client #6 will learn to brush teeth for 30 seconds. Staff will assist after 30 seconds to ensure client #6's teeth are cleaned thoroughly." Subsequent review of the oral hygiene objective for client #6 also revealed prior programs have shown, the is able to cooperate with staff assisting in brushing his teeth. Further review of client #6's record revealed a dental consultation dated 5/26/21. Review of the consultation indicated "this patient is dependent on staff for daily oral care." Interview with the QIDP on 11/9/21 confirmed all clients should be supported to follow appropriate hygiene needs and programming as prescribed.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to provide teaching relative to eyeglasses for 1 non-sampled client (#1) and failed to ensure cleanliness and good repair of wheelchairs for 2 non-sampled clients (#3 and #5). The findings are:	W 436		

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W 436	Continued From page 8 A. The facility failed to teach client #1 to use and make informed choices relative to eyeglasses. For example: Observations at the day program and the group home throughout the 11/8-9/21 survey revealed client #1 to be engaged in various activities including chores, leisure activities, and mealtimes. At no time during survey observations was client #1 observed wearing eyeglasses or for staff to prompt client #1 to wear his eyeglasses. Observation at the group home at 9:00 AM on 11/9/21 revealed all clients to load the facility van for transport to the day program. Interview with the house manager (HM) at 9:05 AM revealed client #1 has eyeglasses, but does not like to wear them and often refuses to wear them when prompted. Further observation at 9:06 AM revealed the HM to prompt client #1 to exit the van and retrieve the eyeglasses from inside the home. Subsequent observation revealed client #1 to return to the van with eyeglasses. Observation of client #1's eyeglasses revealed the lenses to be smudged and dirty. Review of client #1's record revealed a person-centered plan (PCP) dated 5/7/21. Review of client #1's PCP revealed the client wears eyeglasses daily. Further review of client #1's record revealed an eye exam dated 4/13/21. Review of the eye exam indicated client #1 has a diagnosis of dry eye syndrome and diabetes. Interview with the qualified intellectual disabilities professional (QIDP) on 11/9/21 confirmed client #1 should be wearing eyeglasses as prescribed and the lenses should be cleaned regularly.	W 436		

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W 436	Continued From page 9 Continued interview with the QIDP verified client #1 did not have a current program to address the need to wear eyeglasses as prescribed or to address the cleaning of his eyeglasses. B. The facility failed to ensure wheelchairs were clean and in good repair for client #3 and #5. For example: Observations in the group home on 11/9/21 at 7:15 AM revealed client #3 to use a wheelchair for ambulation. Continued observation of the wheelchair for client #3 revealed dried food debris and spillage on the right armrest. Further observation revealed client #5 to also ambulate with the use of a wheelchair. Observation of the wheelchair for client #5 revealed a hole in the cover of the right arm rest with exposed internal padding, a missing tipper on the left side, back of the wheelchair and the seat strap and chest harness to have dried food debris. Interview with the facility home manager on 11/9/21 revealed adaptive equipment is cleaned on third shift. Continued interview with the home manager verified the wheelchairs for client #3 and #5 did not look clean. Interview with the QIDP on 11/9/21 revealed the were no current work orders for client #5's wheelchair.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is:	W 440		

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W 440	Continued From page 10 Review of the facility fire drill reports on 11/8/21 revealed during the 12 month review period from December 2020 to November 2021, three out of four quarterly periods were missing the required fire drills. Further review revealed no evidence of second or third shift drills conducted during the first quarter, no evidence of third shift drills conducted during the second quarter, and no evidence of first shift drills conducted during the third quarter. Continued review revealed no evidence of third shift drills conducted from December 2020 to June 2021. Interview with the qualified intellectual disabilities professional (QIDP) on 11/9/21 verified there was no evidence the facility had completed the required fire drills for the review period. Continued interview with the QIDP confirmed fire drills should have been conducted quarterly for each shift of personnel.	W 440		