		AND HUMAN SERVICES & MEDICAID SERVICES			Ο		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				२ 05/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	DOK GROUP HOME				801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 037}	CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1).	(1) 16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 8.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1),	{E 03	37}			
	Hospitals at §482.1 at §484.102, REHs under §485.727, OF RHC/FQHCs at §49 (1) Training progra the following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide emergen least every 2 years. (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For Hospices at § hospice must do all (i) Initial training in e policies and proced hospice employees	21.12:] m. The [facility] must do all of emergency preparedness ures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at entation of all emergency ng. aff knowledge of emergency y preparedness policies and hificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 02/07/2024

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.

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		34G237	B. WING		R 02/05/2024		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEBR	DOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
{E 037}	procedures. (iii) Provide emerge least every 2 years. (iv) Periodically revi emergency prepare employees (includir special emphasis p procedures necession others. (v) Maintain documpreparedness traini (vi) If the emergence procedures are sign must conduct training procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial training procedures. (iii) Demonstrate sta- procedures. (iv) Maintain documpreparedness traini (v) If the emergency procedures are sign must conduct training procedures. (iv) Maintain documpreparedness traini (v) If the emergency procedures. *[For PACE at §460 organization must of	aff knowledge of emergency ency preparedness training at ew and rehearse its edness plan with hospice ing nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ng. by preparedness policies and inficantly updated, the hospice ing on the updated policies and 1.184(d):] (1) Training must do all of the following: emergency preparedness ures to all new and existing by ding services under volunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	{E 03	77}			

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				R <b>05/2024</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 037}	policies and proced staff, individuals pro arrangement, contra volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includir what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct trainin procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all co (i) Provide initial trai preparedness polici and existing staff, in	lures to all new and existing poiding on-site services under actors, participants, and ent with their expected roles. ncy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in ncy. nentation of all training. cy preparedness policies and nificantly updated, the PACE ng on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their ncy preparedness training at nentation of all emergency ing. aff knowledge of emergency iss and procedures to all new ndividuals providing services , and volunteers, consistent	{E 0	37}			

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				R <b>05/2024</b>
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{E 037}	<ul> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum</li> <li>(iv) Demonstrate staprocedures. All new and assigned speci the CORF's emerger their first workday.</li> <li>include instruction in alarm systems and equipment.</li> <li>(v) If the emergen procedures are sign must conduct training procedures.</li> <li>*[For CAHs at §485 The CAH must do at (i) Initial training in e policies and proced reporting and exting and where necessan personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, con roles.</li> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum (iv) Demonstrate staprocedures.</li> <li>(v) If the emergen procedures.</li> </ul>	ncy preparedness training at nentation of the training. aff knowledge of emergency v personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must n the location and use of signals and firefighting cy preparedness policies and hificantly updated, the CORF ng on the updated policies and 5.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at	{E 0	37}			

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		AND HUMAN SERVICES			FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING	 		R 05/2024
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME			01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 037}	*[For CMHCs at §4. CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on record re failed to ensure dire the facility's emerge at least biennially. T Review on 12/5/23 no evidence of initia EPP. Interview on 12/6/23 verified that initial a current staff had no knowledge. During the follow-up with the Program M facility has not com Therefore, the facili EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §482 §485.542(d)(2), §482	85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new individuals providing services t, and volunteers, consistent roles, and maintain he training. The CMHC must mowledge of emergency eafter, the CMHC must provide edness training at least every 2 s not met as evidenced by: eview and interview, the facility ect care staff were trained on ency preparedness plan (EPP) The finding is: of the facility's EPP revealed al or biennial training on the 3 with the facility administrator of been completed to her p survey on 2/5/24, interview fanager revealed that the ipleted the Plan of Correction. ity remains out of compliance. ements	{E 03			

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		34G237	B. WING	i			R 05/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	DOK GROUP HOME			-	01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	Continued From pa	ige 5	{E 0:	39}			
	at §485.542, OPO, §485.727, CMHCs	6.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:					
		cility] must conduct exercises acy plan annually. The [facility] ollowing:					
	<ul> <li>(i) Participate in a fu community-based et</li> <li>(A) When a community-based et</li> <li>(A) When a community-based et</li> <li>(A) When a community-based et</li> <li>(B) If the [facility natural or man-mached activation of the emerged community-based et</li> <li>(activation of the emerged community-based et</li> <li>(actual event.</li> <li>(b) A second full-section is condu- not limited to the following exercise;</li> <li>(B) A mock disaster</li> <li>(C) A tabletop exerce a facilitator and incla a narrated, clinically scenario, and a set directed messages, designed to challen</li> </ul>	ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based ; or					

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				R <b>05/2024</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME			-	801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	maintain document exercises, and eme [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. Th exercises to test the annually. The hosp (i) Participate in a f community based ef (A) When a commu accessible, conduct functional exercise (B) If the hospice ef man-made emerge the emergency plar engaging in its next community-based functionset of the emergen (ii) Conduct an add opposite the year th exercise under para is conducted, that in to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen	ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] pices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from t required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	{E 0	39}			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/07/2024 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED		
		34G237	B. WING	i			R <b>05/2024</b>		
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
{E 039}	care directly. The h exercises to test the year. The hospice f (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the hospice ex- man-made emergen the emergency plan engaging in its next based or facility-base following the onset (ii) Conduct an add may include, but is (A) A second full-sec community-based of exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hose maintain documenta exercises, and emerge (iii) Analyze the hose maintain documenta exercises, and emerge (iii) Conduct exercises to *[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF	hospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or xperiences a natural or ncy that requires activation of n, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or cise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. 1.184(d), Hospitals at	{E 0	39}					

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	<ul> <li>(i) Participate in an is community-based</li> <li>(A) When a community-based</li> <li>(A) When a community-based function</li> <li>(B) If the [PRTF, Head actual natural or marequires activation of [facility] is exempt for required full-scale of facility-based function</li> <li>(actual natural or marequires activation of [facility] is exempt for required full-scale of facility-based functions of the emerge (ii) Conduct an and that may include following:</li> <li>(A) A second full-scale of functional exercise;</li> <li>(B) A mock (C) A tabletop of led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan.</li> <li>(iii) Analyze the maintain document exercises, and emergency</li> <li>*[For PACE at §460 (2) Testing. The PACE following:</li> </ul>	annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. 0.84(d):] CE organization must conduct e emergency plan at least i organization must do the	{E 0	39}			

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{E 039}	<ul> <li>(A) When a communication of the energy of the energy plane engaging in its next based or individual, exercise following the event.</li> <li>(ii) Conduct an every event.</li> <li>(iii) Conduct an every event.</li> <li>(A) A second full-second functional exercise;</li> <li>(B) A mock disaster</li> <li>(C) A tabletop every a facilitator and inclusing a narrated, clis scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documentate every every *[For LTC Facilities (2) The [LTC facility test the emergency procedul ICF/IID] must do the every every for the every every</li></ul>	unity-based exercise is not t an annual individual, ional exercise; or periences an actual natural or incy that requires activation of n, the PACE is exempt from t required full-scale community , facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based ; or er drill; or rcise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. ACE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):] of must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that	{E 0	39}			

		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	<ul> <li>(A) When a communication of the image of the ima</li></ul>	inity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or er drill; or cise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises icy plan at least twice per year. o the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual,	{E 0	39}			

		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
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PINEBRO	OOK GROUP HOME			-	301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
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{E 039}	the emergency plan engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is in (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and inclu- using a narrated, cli- scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documenta exercises, and emer ICF/IID's emergenc '[For HHAs at §484 (d)(2) Testing. The I to test the emergen least annually. The (i) Participate in a fu community-based; co (A) When a con accessible, conduct facility-based function or. (B) If the HHAA emergen engaging in its next community-based of	h, the ICF/IID is exempt from trequired full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based for r drill; or cise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. F/IID's response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. I.102] HHA must conduct exercises hey plan at HHA must do the following: ull-scale exercise that is or mmunity-based exercise is not t an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from	{E 03	39}			

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NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{E 039}	emergency event. (ii) Conduct an addi opposite the year the exercise under para is conducted, that limited to the followin (A) A second fur- community-based of functional exercise; (B) A mock disa (C) A tabletop er- led by a facilitator and discussion, using an emergency scenario statements, directed questions designed plan. (iii) Analyze the HHA documentation of an emergency events, emergency events, emergency plan, ass *[For OPOs at §486 (d)(2) Testing. The of to test the emergency following: (i) Conduct a paper- workshop at least and led by a facilitator and discussion, using an emergency scenario statements, directed questions designed plan. If the OPO expension man-made emergency the emergency plan.	itional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section t may include, but is not ing: Ill-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency A's response to and maintain Il drills, tabletop exercises, and and revise the HHA's s needed.	{E 0	039	>>		

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				R <b>05/2024</b>
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBR	OOK GROUP HOME				01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	<ul> <li>(ii) Analyze the OPC documentation of a emergency events, OPO's] emergency</li> <li>*[ RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant error of problem statemergency plan. (ii) Analyze the RNI maintain document and emergency plan. (ii) Analyze the RNI maintain document and emergency plan, as This STANDARD is Based on record refailed to conduct expreparedness plan</li> <li>Review of the facilit of a full-scale or conexercise.</li> <li>Interview with the fat that there has not b based exercise nor drill to her knowledge.</li> </ul>	O's response to and maintain ill tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's s needed. s not met as evidenced by: eview and interview, the facility cercises to test the emergency (EPP) annually. For example, ty EPP revealed no evidence mmunity-based training	{E 0	39}			

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING			R 02/05/2024	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				1 ERKWOOD DRIVE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{W 125} {W 125}	PROTECTION OF CFR(s): 483.420(a)	CLIENTS RIGHTS	{W 12 {W 12	-			
	Therefore, the facili individual clients to of the facility, and a including the right to to due process. This STANDARD is Based on observat failed to ensure the were protected with	ity must allow and encourage exercise their rights as clients is citizens of the United States, o file complaints, and the right s not met as evidenced by: tions and interviews, the facility rights of 1 of 6 clients (#6) n respect to freedom of environment. The finding is:					
	and group home the 12/5/23 and 12/6/23 attempt to get up an placement and the #6 stood up and wa	s in the vocational program roughout the survey on 3, client #6 was observed to nd walk around the day group home. Each time client alked, staff told him to sit ff physically redirected client or on the couch.					
	and the habilitation	3 with the facility administrator specialist confirmed that client o move freely around his					
{W 130}	with the Program M facility has not com Therefore, the facili		{W 13	30}			
		nsure the rights of all clients. ity must ensure privacy during					

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		AND HUMAN SERVICES			FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING	 		R <b>05/2024</b>
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME			01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 130} {W 186}	treatment and care This STANDARD is Based on observat failed to ensure the were protected with and treatment. The During observations 12/5/23 staff were of from his wheelchair client's bedroom wh naked and the bedr Interview on 12/6/23 and the habilitation #3 should be given treatment. DIRECT CARE STA CFR(s): 483.430(d) The facility must pro- staff to manage and	of personal needs. s not met as evidenced by: tions and interviews, the facility rights of 1 of 6 clients (#3) respect to privacy during care finding is: s in the group home on observed to move client #3 to his shower chair inside the hile client #3 was completely room door open. 3 with the facility administrator specialist confirmed that client privacy during care and AFF	{W 1			
	on-duty staff calcula period for each defi This STANDARD is Observations in the 6:30 AM revealed S supervising all 6 clie #4, #5, and #6). Co that client #3 was a Further observation to the group home at group home at 7:53 observations reveal	e defined as the present ated over all shifts in a 24-hour ined residential living unit. s not met as evidenced by: e group home on 12/6/23 at Staff A to be on duty and ents in the home (#1, #2, #3, ntinued observation revealed wake and lying in his bed. n revealed that Staff B arrived at 7:50 AM and Staff A left the B AM. Subsequent led that Staff B began passing AM, at which point Staff B				

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G237	B. WING				R <b>05/2024</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				D1 ERKWOOD DRIVE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 186} {W 249}	<ul> <li>was in the medicati surveyor with the depresent in the home</li> <li>Additional observation client #2's bedrownile</li> <li>Staff B was sino other staff were</li> <li>opened the medication</li> <li>out of the room or scient #2 to return to</li> <li>Review of records fiperson-centered plaindicates that he reduce to a history of a Continued review of physical therapy evoluent #4 which india</li> <li>Interview with the fathe group home was staff to client ratio be the facility between 12/6/23.</li> <li>During the follow-up with the Program M facility has not com Therefore, the facility PROGRAM IMPLE CFR(s): 483.440(d)</li> </ul>	ion room with client #6 and oor closed and no other staff e. ions revealed that the alarm bom door alerted at 8:07 AM, till in the medication room and present. At that time, Staff B tion room door, but did not go see client #2, and directed o his bedroom. for client #2 revealed a an (PCP) dated 4/11/23 which quires line of sight supervision absconding behavior. of records revealed current raluations for client #3 and cated they require 2-peson or rs and are dependent on staff laily living. acility administrator confirmed as not within the appropriate based on identified needs of 6:30 AM and 8:18 AM on p survey on 2/5/24, interview fanager revealed that the pleted the Plan of Correction. ity remains out of compliance. MENTATION 0(1) erdisciplinary team has s individual program plan,	{W 18		DEFICIENCY)		
		ceive a continuous active					

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING	;			R 05/2024
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINEBRO	OOK GROUP HOME				01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 249}	Continued From particular treatment program interventions and search objectives identified plan. This STANDARD is Based on observation interviews, the facilit received a continue consisting of needer as identified in the F for 4 of 6 clients (#2 implementing training adaptive equipment #2's safety. For examplement on 12/5/23 at the without the Arr staff whenever clier area. Further obser leave the group hor 12/5/23 to take out vocational center and PM on 12/6/23, again Record review on 1 person-centered placting from variables.	age 17 consisting of needed ervices in sufficient number upport the achievement of the d in the individual program s not met as evidenced by: tions, record reviews and ity failed to ensure clients ous active treatment program ed interventions and services Person-Centered Plan (PCP) 2, #3, and #6) relative to ng objectives and providing t. The findings are: d to provide prescribed t necessary to maintain client ample: e group home and vocational and 12/6/23 revealed client #1 ngel Watch device which alerts in #2 leaves a supervised rvation revealed client #2 to me alone 1t 5:33 PM on the trash and to leave the lone at approximately 12:45 ain to take items to the trash. 12/5/23 revealed a an (PCP) dated 4/11/23 for cribes a history of client #2 arious caregivers and	{W 2				
	avoid detection. Co	nistic behaviors in order to ontinued record review CP calls for the use of a watch					

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				२ 05/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 249}	device which monit notifies staff when H supervision. The PC be worn by client #2 Interview with the fa that client #2's PCF should ensure that Watch device for hi hours. B. The facility failed activities or implem client #3 during larg leisure time. For ex Observations in the revealed client #3 to which was parked i television. Continue #1 to remain in that 6:11 PM, except for wheeled him to the dinner. Further obs minimal interaction same period and di preferred items or a observation reveale propel his wheelcha on staff for all need Observation in the f 6:30 AM until 8:50 A his bed awake and 8:50 AM, staff used #2 from his bed to F client #3 in the living television, where he	ors client #2's movements and he has left an area of CP states that this device is to 2 during all waking hours. acility administrator confirmed P is current, and that staff client #2 is wearing the Angel s safety during all waking I to provide meaningful ent training objectives for ge amounts of unstructured ample: e group home on 12/5/23 to be seated in his wheelchair n the living room facing the ed observation revealed client t situation from 4:30 PM until a 22-minute period when staff dining room where he ate ervation revealed staff had with client #3 during that d not offer him any of his activities. Additional ed that client #3 is unable to air independently and depends	{W 2	49}			

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		AND HUMAN SERVICES				FORM	: 02/07/2024 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		34G237	B. WING	i			R <b>05/2024</b>
NAME OF	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINEBR	OOK GROUP HOME				801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
{W 249}	before staff returne front of the televisio observation at 9:30 revealed staff had r #3 during that same any of his preferred Record review on 1 client #3 dated 7/31 #3 enjoys tablet gan and interactive lear review revealed a s say the names of st of flashcards. Interview with the fa that client #3's PCF should assist client items and activities client #3's goals an C. The facility failed activities or implem client #6 during larg leisure time. For ex Observations in the revealed client #6 to facing the televisior Continued observat remain in that situa PM, when he ate hi Immediately after fi directed to sit on th to go to his bedroor revealed client #6 to couch and staff to r back down until 5:5	Ad him to the living room in on until the end of the AM. Further observation minimal interaction with client e period and did not offer him d items or activities. (2/5/23 revealed a PCP for 1/23 which indicates that client mes, music, board games, ning toys. Continued record specific training objective to hapes and colors with the use acility administrator confirmed P is current, and that staff #3 to access his preferred and should consistently train d objectives. d to provide meaningful pent training objectives for ge amounts of unstructured	{W 2	49}			

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G237	B. WING				R <b>05/2024</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBR	OOK GROUP HOME				01 ERKWOOD DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 249}	that when client #5 6:08 PM, he was ag couch and remaine observations at 6:3 Observations in the revealed client #6 to 7:56 AM, and to be specific chair and w medication room. Of client #6 to be seate direction of staff fro morning observatio minutes during white dining room. Further every time client #6 couch, staff redirect one occasion, clien requested coffee an and wait for it. Addit that no staff used a at any time during t was one visible in th Record review on 1 client #6 dated 11/1 thoroughly washing participating in oral participating in com month, hanging up making his bed, an with staff assist. Th should routinely stru- series of pictures d should use the pror assist client #6 thro incorporate preferre	returned from the shower at gain directed to sit on the ed there until the end of 0 PM. e group home on 12/5/23 o be out of bed and dressed at directed by staff to sit in a vait to be called into the Continued observation revealed ed in the living room at the om 8:18 AM until the end of ons at 9:30 AM, except for 10 ch he ate breakfast in the er observations revealed that 6 attempted to get up from the sted him to sit back down. On t #6 went to the kitchen and nd was, again, told to sit down itional observations revealed a visual schedule with client #6 the observation period, nor	{W 24	49}			

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		AND HUMAN SERVICES					FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		34G237	B. WING			R 02/05/2024		
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP C	ODE		
PINEBRO	OOK GROUP HOME				RKWOOD DRIVE DERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
{W 249} {W 440}	client #6 communic pointing and that the communication tool time. Interview with the fat that client #6's PCP interview confirmed #6 to use a visual s routine and that the opportunities for me preferred leisure ac client #6 on his ider During the follow-up with the Program M facility has not com Therefore, the facili EVACUATION DRII CFR(s): 483.470(i)( at least quarterly for This STANDARD is Based on record ref	A on 12/5/23 revealed that cates with staff mostly by ere is no visual available in the home at this acility administrator confirmed P is current. Continued that staff should assist client chedule as part of his daily by should offer client #6 eaningful engagement with ctivities and items, and train ntified objectives and goals.	{W 24		DEFICIENCY)			
	finding is: A review of the facil revealed that betwe facility conducted 11 only one occurred of	ach shift of personnel. The lity fire drill reports on 12/5/23 een 12/1/22 and 11/3/23, the 2 fire drills, but that of those, on third shift. All other drills						
	Interview with the fa	tween 9:00 AM and 4:02 PM. acility administrator on 12/6/23 should have been conducted hift of personnel.						

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		AND HUMAN SERVICES				FORM	02/07/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		34G237	B. WING	i			R <b>05/2024</b>
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				1 ERKWOOD DRIVE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{W 440}	Continued From pa	ige 22	{W 4	40}			
{W 474}	with the Program M facility has not com Therefore, the facili	p survey on 2/5/24, interview lanager revealed that the pleted the Plan of Correction. ity remains out of compliance. )(2)(iii)	{W 4	74}			
	developmental leve This STANDARD is Record review on 7 person-centered pla	s not met as evidenced by: 12/5/23 revealed a an (PCP) for client #4 dated : client #5 is currently on a nd requires ground					
		acility Administrator confirmed d have been provided with a / diet for all foods.					
	D. The facility failed for client #6. For ex	d to ensure the prescribed diet cample:					
	staff to serve a who and rice pilaf to clie	e same dinner meal revealed ble pot pie, whole green beans ent #6, and client #6 to without staff cutting up or in any manner.					
	meal revealed staff slices of bacon to c	2/6/23 of the same breakfast to serve oatmeal and whole lient #6, and client #6 to without staff cutting up or in any manner.					
	Record review on 1 person-centered pla	2/5/23 revealed a an (PCP) for client #6 dated					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 02/07/2024 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY MPLETED
		34G237	B. WING	i			к /05/2024
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEBRO	OOK GROUP HOME				801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
{W 474}	11/15/23 stating that heart healthy diet a all foods. Interview with the F that client #6 should ground consistency During the follow-up with the Program M facility has not com	at client #6 is currently on a and requires ¼" consistency for cacility Administrator confirmed d have been provided with a	{W 4	74}			

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