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 ______	R 03/08/2024

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 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 observations, record reviews and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person-Centered Plan (PCP) for 4 of 6 clients (#2, #3, and #6) relative to implementing training objectives and providing adaptive equipment. The findings are: A. The facility failed to provide prescribed adaptive equipment necessary to maintain client #2's safety. For example: Observations in the group home and vocational center on 12/5/23 and 12/6/23 revealed client #1 to be without the Angel Watch device which alerts staff whenever client #2 leaves a supervised area. Further observation revealed client #2 to leave the group home alone 1t 5:33 PM on 12/5/23 to take out the trash and to leave the vocational center alone at approximately 12:45 PM on 12/6/23, again to take items to the trash. Record review on 12/5/23 revealed a person-centered plan (PCP) dated 4/11/23 for	{W 249}		

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

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 249}	Continued From page 1 client #2 which describes a history of client #2 absconding from various caregivers and displaying opportunistic behaviors in order to avoid detection. Continued record review revealed that the PCP calls for the use of a watch device which monitors client #2's movements and notifies staff when he has left an area of supervision. The PCP states that this device is to be worn by client #2 during all waking hours. Interview with the facility administrator confirmed that client #2's PCP is current, and that staff should ensure that client #2 is wearing the Angel Watch device for his safety during all waking hours. B. The facility failed to provide meaningful activities or implement training objectives for client #3 during large amounts of unstructured leisure time. For example: Observations in the group home on 12/5/23 revealed client #3 to be seated in his wheelchair which was parked in the living room facing the television. Continued observation revealed client #1 to remain in that situation from 4:30 PM until 6:11 PM, except for a 22-minute period when staff wheeled him to the dining room where he ate dinner. Further observation revealed staff had minimal interaction with client #3 during that same period and did not offer him any of his preferred items or activities. Additional observation revealed that client #3 is unable to propel his wheelchair independently and depends on staff for all needs. Observation in the group home on 12/6/23 from 6:30 AM until 8:50 AM revealed client #3 to be in his bed awake and drinking from a baby bottle. At	{W 249}		

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{W 249}	Continued From page 2 8:50 AM, staff used a 2-person lift to move client #2 from his bed to his wheelchair, then placed client #3 in the living room in front of the television, where he remained until 9:15 AM. Client #3 then ate his breakfast in the dining room before staff returned him to the living room in front of the television until the end of the observation at 9:30 AM. Further observation revealed staff had minimal interaction with client #3 during that same period and did not offer him any of his preferred items or activities. Record review on 12/5/23 revealed a PCP for client #3 dated 7/31/23 which indicates that client #3 enjoys tablet games, music, board games, and interactive learning toys. Continued record review revealed a specific training objective to say the names of shapes and colors with the use of flashcards. Interview with the facility administrator confirmed that client #3's PCP is current, and that staff should assist client #3 to access his preferred items and activities and should consistently train client #3's goals and objectives. C. The facility failed to provide meaningful activities or implement training objectives for client #6 during large amounts of unstructured leisure time. For example: Observations in the group home on 12/5/23 revealed client #6 to be seated in the living room facing the television which was playing a movie. Continued observation revealed client #6 to remain in that situation from 4:30 PM until 5:00 PM, when he ate his dinner in the dining room. Immediately after finishing his meal, client #6 was directed to sit on the couch and was not allowed	{W 249}		

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{W 249}	Continued From page 3 to go to his bedroom. Further observation revealed client #6 to repeatedly get up from the couch and staff to repeatedly direct client #5 to sit back down until 5:55 PM, when client #6 went to take a shower. Subsequent observation revealed that when client #5 returned from the shower at 6:08 PM, he was again directed to sit on the couch and remained there until the end of observations at 6:30 PM. Observations in the group home on 12/5/23 revealed client #6 to be out of bed and dressed at 7:56 AM, and to be directed by staff to sit in a specific chair and wait to be called into the medication room. Continued observation revealed client #6 to be seated in the living room at the direction of staff from 8:18 AM until the end of morning observations at 9:30 AM, except for 10 minutes during which he ate breakfast in the dining room. Further observations revealed that every time client #6 attempted to get up from the couch, staff redirected him to sit back down. On one occasion, client #6 went to the kitchen and requested coffee and was, again, told to sit down and wait for it. Additional observations revealed that no staff used a visual schedule with client #6 at any time during the observation period, nor was one visible in the group home. During the second follow-up survey on 3/8/24, observations, record review and interview with the Executive Director revealed that the facility has not completed the Plan of Correction. Therefore, the facility remains out of compliance.	{W 249}		