OMB NO. 0938-0391

PLAN OF CO	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		34G237	B. WING	3		
NAME OF B	ADOLUMEN OF START AND	340237				06/2023
	PROVIDER OR SUPPLIER  OOK GROUP HOME			street address, city, state, zip co 301 erkwood drive HENDERSONVILLE, NC 28791	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLET DATE
	§441.184(d)(1), §460. §483.73(d)(1), §483. §485.68(d)(1), §485.68(d)(1), §485.727(d)(1).  *[For RNCHIs at §40.15, §484.102, REHs at §40.15, §484.102, REHs at §40.101, §49.112(d)(1).  *[For RNCHIs at §40.15, §484.102, REHs at §40.101, REHs at §40.101, REHs at §40.101, Training program following:  (i) Initial training production policies and procedure individuals providing volunteers, consistent (ii) Provide emericant every 2 years.  (iii) Maintain doc preparedness training (iv) Demonstrate procedures.  (v) If the emerge procedures are significant training on the procedures.  *[For Hospices at §41, hospice must do all of (i) Initial training in earn procedures to all a temployees, and individual arrangement, consistent	1) 6.54(d)(1), §418.113(d)(1), 0.84(d)(1), §482.15(d)(1), 475(d)(1), §484.102(d)(1), 485.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1), 03.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs at 485.542, "Organizations" Os at §486.360, 1.12:] a. The [facility] must do all of the ag in emergency preparedness res to all new and existing staff, as services under arrangement, and at with their expected roles. Argency preparedness training at cumentation of all emergency action of all emergency and cantly updated, the [facility] must be updated policies and (8.113(d):] (1) Training. The	E 037	RHA Health Services will ensing compliance with all CMS grelated to Emergency plans and team will ensure all Emergency Plan trainings are done correct current staff and as new staff a Drills will be returned and tracoffice as well as leaving a cophome. All DSP's and RTL will on Emergency Drill's. Fire drimonthly in the corporate safetymonths.  RECEIVIAN 17 202  DHSR-MH Licensure	suidelines as ad supplies. IDT by Preparedness thy and with all are hired. All cked at the main by at the group at the group are bein-serviced as will be audited by meeting for 3	6) 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

OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:USSF11

Facility ID: 922389

If continuation sheet Page 1 of 25

NAME OF PROVIDER OR SUPPLIER  PINEBROOK GROUP HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFY NO INFORMATION)  E 037  Continued From page 1  (ii) Demonstrate staff knowledge of emergency procedures, (iii) Provide emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures are significantly updated, the hospice must conduct training on the updated policies and procedures are significantly updated, the hospice must conduct training in emergency preparedness policies and procedures to all the respected roles.  (iii) After initial training, provide emergency preparedness training wavey 2 years. (iv) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (iii) After initial training in emergency preparedness training. (v) If the emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (iii) Demonstrate staff knowledge of emergency preparedness training every 2 years. (iv) Maintain documentation of all emergency preparedness training every 2 years. (iv) Minitain documentation of all emergency preparedness training every 2 years. (iv) Minitain documentation of all emergency preparedness training in emergency preparedness training in the updated, the PRTF must conduct training on the updated policies and procedures.  *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness training.	STATEMENT PLAN OF CO	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
PINEBROOK GROUP HOME  (KIGHD SUMMANY STATEMENT OF DEFICIENCES)  (REACH DEFICIENCY MIST BE PRECEDED BY FILL  (RECULATORY OR LSC IDENTIFYING INFORMATION)  E 037  Continued From page 1  (ii) Demonstrate staff knowledge of emergency procedures.  (iii) Provide emergency preparedness training at least every 2 years.  (iv) Periodically review and rehearse its emergency preparedness plain with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures are significantly updated, the hospice must conduct training on the updated policies and procedures are significantly updated, the hospice must conduct training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (iii) After initial training, every 2 years.  (iiii) Demonstrate staff knowledge of emergency preparedness training.  (v) Maintain documentation of all emergency preparedness policies and procedures are significantly updated, the hospice must conduct training in emergency preparedness policies and procedures.  *[For PRTFs at \$441.184(d):] (1) Training program. The PRTF must do all of the following: (i) initial training in emergency preparedness policies and procedures.  (iii) After initial training, every 2 years.  (iii) Demonstrate staff knowledge of emergency preparedness training.  (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated.			34G237	B. WING			12/	06/2023
PINEBROOK GROUP HOME   SUMMANY STATEMENT OF DEFICIENCIES   SUMMANY STATEMENT OF DEFICIENCIES   (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMERTION   PREFIX TAG   (ii)   Demonstrate staff knowledge of emergency procedures.   (iii)   Drovide emergency preparedness praining at least every 2 years.   (iv)   Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.   (v)   Maintain documentation of all emergency preparedness praining.   (vi)   If the emergency preparedness praining.   (vi)   If the emergency preparedness praining and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.   (ii)   After initial training, provide emergency preparedness training every 2 years.   (iii)   Demonstrate staff knowledge of emergency preparedness training.   (v)   If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.   (iii)   PRACE at \$460.84(d):] (1) The PACE organization must do all of the following: (i)	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	00/2023
E 037  Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness patients and others.  **[For PRTFs at \$441.184(d):] (1) Training program. The PRTF must do all of the following: (i) initial training in emergency preparedness training emergency preparedness training emergency preparedness training emergency preparedness training emergency preparedness follows and procedures.  *[Io PRTFs at \$441.184(d):] (1) Training program. The PRTF must do all of the following: (i) initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency preparedness training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.  *[For PACE at \$460.84(d):] (1) The PACE organization must do all of the following: (i)						2010 Particular Control (100 Victoria) (200 Victori		10.00
Continued From page 1  (ii) Demonstrate staff knowledge of emergency procedures.  (iii) Provide emergency preparedness training at least every 2 years.  (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.  (v) Maintain documentation of all emergency preparedness training.  (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.  *[For PRTFs at \$441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff; individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (ii) After initial training, provide emergency preparedness raining every 2 years.  (iii) Demonstrate staff knowledge of emergency preparedness training every 2 years.  (iv) Maintain documentation of all emergency preparedness training every preparedness training.  (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.  *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i)		(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		rag .	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
(ii) Demonstrate staff knowledge of emergency procedures.  (iii) Provide emergency preparedness training at least every 2 years.  (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.  (v) Maintain documentation of all emergency preparedness raining.  (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.  *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (ii) After initial training, provide emergency preparedness training every 2 years.  (iii) Demonstrate staff knowledge of emergency preparedness training every 2 years.  (iv) Maintain documentation of all emergency preparedness training every preparedness training every conduct training on the updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures are significan	E 037			Е (	)37			
		(ii) Demonstrate procedures.  (iii) Provide emerleast every 2 years.  (iv) Periodically preparedness plan win nonemployee staff), varying out the procedures and others.  (v) Maintain doc preparedness training (vi) If the emerge procedures are significant training on the procedures.  *[For PRTFs at §441. The PRTF must do all training in emergency procedures to all new providing services unconsistent with their edii) After initial to preparedness training (iii) Demonstrate procedures.  (iv) Maintain doc preparedness training.  (v) If the emerge procedures are significant training on the procedures.  *[For PACE at §460.8 organization must do and training on the procedures.	review and rehearse its emergency th hospice employees (including with special emphasis placed on edures necessary to protect cumentation of all emergency the hospice employees (including with special emphasis placed on edures necessary to protect cumentation of all emergency to protect cumentation of all emergency to preparedness policies and ideantly updated, the hospice must ne updated policies and and existing staff, individuals der arrangement, and volunteers, expected roles. Training, provide emergency every 2 years. Staff knowledge of emergency umentation of all emergency umentation of all emergency ency preparedness policies and cantly updated, the PRTF must be updated policies and cantly updated, the PRTF must be updated policies and cantly including the following: (i)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/15/2023 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT PLAN OF CO	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		E SURVEY PLETED
		34G237			12	/06/2023
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CO 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE	(X5) COMPLETION DATE
E 037		Demonstrate staff knowledge of emergency occdures, including informing participants of what do, where to go, and whom to contact in case of an altergency.  Maintain documentation of all training.(v) If the emergency preparedness policies and procedures as significantly updated, the PACE must conduct ining on the updated policies and procedures.  For LTC Facilities at §483.73(d):] (1) Training or the LTC facility must do all of the lowing:				
	policies and procedu individuals providing arrangement, contract consistent with their emergency preparedry years.  (iii) Demonstrate procedures, including to do, where to go, are emergency.  (iv) Maintain doo the emergency preparare significantly updat training on the update *[For LTC Facilities Program. The LTC fat following:  (i) Initial training policies and procedure individuals providing volunteers, consistent (ii) Provide emergency consistent (iii) Provide emergency preparate annually.  (iii) Maintain doo preparedness training (iv) Demonstrate procedures.  *[For CORFs at §485 CORF must do all of initial training in emeand procedures to all individuals providing	res to all new and existing staff, g on-site services under stors, participants, and volunteers, expected roles. (ii) Provide ness training at least every 2  staff knowledge of emergency g informing participants of what and whom to contact in case of an examentation of all training.(v) If redness policies and procedures atted, the PACE must conduct ed policies and procedures.  at §483.73(d):] (1) Training cility must do all of the  g in emergency preparedness ses to all new and existing staff, services under arrangement, and with their expected role.  regency preparedness training at umentation of all emergency				

STATEMENT PLAN OF CO	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	1 (3	E SURVEY PLETED
		34G237	B. WING		12	10.6.12.02.2
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	12/	/06/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DI	O BE	(X5) COMPLETION DATE
	least every 2 years. (iii) Maintain doc Demonstrate staff knot procedures. All new passigned specific resp CORF's emergency pworkday. The training instruction in the loca and signals and firefig (v) If the emergency procedures are significant training on the procedures.  *[For CAHs at §485.6] The CAH must do all (i) Initial training policies and procedurand extinguishing of the necessary, evacuation guests, fire prevention firefighting and disast existing staff, individuarrangement, and voluexpected roles. (ii) Provide emergleast every 2 years. (iii) Maintain doct Demonstrate staff kno procedures. (v) If the emergency	rigency preparedness training at rumentation of the training.(iv) powledge of emergency personnel must be oriented and ponsibilities regarding the lan within 2 weeks of their first grogram must include ution and use of alarm systems ghting equipment.  The preparedness policies and cantly updated, the CORF must be updated policies and cantly updated, the corresponding in emergency preparedness es, including prompt reporting fires, protection, and where of patients, personnel, and and cooperation with er authorities, to all new and utilize providing services under unteers, consistent with their gency preparedness training at unmentation of the training.(iv) whedge of emergency preparedness policies and cantly updated, the CAH must	E 037			

PLAN OF CO	Γ OF DEFICIENCIES AND DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		E SURVEY PLETED
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		34G237	B. WING _			10 - 12 - 2 -
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I NAME OF	TROVIDER OR SUFFLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
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E 037			E 03	37		
	Continued From pag	re 4				
	*[For CMHCs at §48	35.920(d):] (1) Training. The				
		e initial training in emergency				
		s and procedures to all new and				
-		duals providing services under				
	arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the					
	training. The CMHC must demonstrate staff					
		ency procedures. Thereafter, the				
	CMHC must provide	emergency preparedness training				
	at least every 2 years					
		s not met as evidenced by: Th				
	facBased on record r	eview and interview, the facility t care staff were trained on the				
		preparedness plan (EPP) at least				
	biennially. The findir	preparedness plan (EFF) at least				
	oremnary. The initial	15 15.				
	Review on 12/5/23 o	f the facility's EPP revealed no				
		biennial training on the				ł
	EPP.					İ
	I					
		with the facility administrator				
		nd biennial trainings for current mpleted to her knowledge.				
E 030	EP Testing Requirem	1 0 1	Е 02	O BILA II LI C	1 0 111 1	
L 037	CFR(s): 483.475(d)(2	100000000000000000000000000000000000000	E 03	9 RHA Health Services will ensure in compliance with all CMS guid		
	C11((5): 405:175(u)(2	)		related to Emergency plans and s		
	§416.54(d)(2), §418.1	113(d)(2), §441.184(d)(2),		Program manager, Unit Clerk, R		
		15(d)(2), §483.73(d)(2),		will ensure all Emergency Prepar		1
	§483.475(d)(2), §484	.102(d)(2), §485.68(d)(2),		trainings are done correctly and		1
		.625(d)(2), §485.727(d)(2),		staff and as new staff are hired. F		
	§485.920(d)(2), §491	.12(d)(2), §494.62(d)(2).		ensure that Pinebrook will hold a		
	*FF 100 2111	4 0000		Tabletop training or Full disaster		
		4, CORFs at §485.68, REHs at		required per CMS guidelines. Al	10/111/01200000000000000000000000000000	
		anizations" under §485.727,		returned and tracked at the main		
	ESRD Facilities at §4	RHCs/FQHCs at §491.12, and		as leaving a copy at the group ho		
	Land racinges at 94	74.02].		and RTL will be in-serviced on E	Emergency	
				Drill's. Fire drills will be audited	monthly in	
				the corporate safety meeting for 3	3 months.	

STATEMENT PLAN OF CO	OF DEFICIENCIES AND DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	G	COM	FLETED
		34G237	B. WING	·	12	/06/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	00/2023
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
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E 039			E 039			
	Continued From page	25				
		lity] must conduct exercises to an annually. The [facility] must				
	do all of the following:  (i) Participate in a full-scale exercise that is					
	community-based every 2 years; or  (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or  (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the					
	emergency plan, the [	facility] is exempt from engaging				
		mmunity-based or individual, nal exercise following the onset				
	of the actual event.					
		onal exercise at least every 2				
		ar the full-scale or functional aph (d)(2)(i) of this section is				
	conducted, that may in	nclude, but is not limited to the				
	following: (A) A second full-scale	e exercise that is				
	community-based or is	ndividual, facility-based				
	functional exercise; or or	(B) A mock disaster drill;				
	(C) A tabletop exercise	e or workshop that is led by a				
	facilitator and includes	s a group discussion using a evant emergency scenario, and				
	a set of problem staten	nents, directed messages, or				
	prepared questions des	signed to challenge an				
	to and maintain docum	Analyze the [facility's] response nentation of all drills, tabletop				
	exercises, and emerger	ncy events, and revise the				
	[facility's] emergency	plan, as needed.				
	*[For Hospices at 418.	113(d):]				
		ON 19 C.1				

STATEMENT PLAN OF CO	OF DEFICIENCIES AND PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
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		34G237	B. WING		12	10.6.12.022
NAME OF 1	PROVIDER OR SUPPLIER	- Control of the Cont		STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/06/2023
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
TAG		Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAC	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIATE D	D BE EFICIENCY)	COMPLETION DATE
E 039			E 039			
	patient's home. The hat to test the emergency hospice must do the full-scale exercise that years; or  (A) When a community accessible, conduct are functional exercise events hospice experiences a emergency that require plan, the hospital is exengaging in its next rebased exercise or indivexercise following the (ii) Conduct an addition opposite the year the funder paragraph (d)(2) that may include, but if (A) A second full-community-based or a exercise; or  (B) A mock disast (C) A tabletop execute a facilitator and include narrated, clinically-relessed of problem statemed prepared questions desemble emergency plan.  (3) Testing for hospice of the emergency plan two do the following:	ces that provide care in the mospice must conduct exercises plan at least annually. The following: (i) Participate in a at is community based every 2 ity based exercise is not in individual facility based every 2 years; or (B) If the inatural or man-made respectively activation of the emergency exempt from equired full scale community-vidual facility-based functional exercise every 2 years, full-scale or functional exercise (i) of this section is conducted, is not limited to the following: -scale exercise that is a facility based functional exercise or workshop that is led by des a group discussion using a evant emergency scenario, and a ents, directed messages, or				

STATEMENT PLAN OF CO	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
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1		34G237	B. WING_	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12/	/06/2023
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/2023
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TA	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE APPRO	ON SHOULD BE OPRIATE DEFICIENCY)	COMPLETION DATE
E 039			E 0	39		
	Continued From page	e 7				
		munity-based exercise is not				
	accessible, conduct a	n annual individual facility-based				
		or (B) If the hospice experiences a				
	natural or man-made emergency that requires activation of the emergency plan, the hospice is					
		g in its next required full-scale				
		facility-based functional exercise				
	following the onset of	f the emergency event. (ii)				
	Conduct an additiona	l annual exercise that may				
	include, but is not lim	nited to the following: (A) A				
	facility based function	rcise that is community-based or a				
	(B) A mock disas					
		ercise or workshop led by a				
	facilitator that include	es a group discussion using a				8
	narrated, clinically-re	levant emergency scenario, and a				
		ents, directed messages, or				
	prepared questions de emergency plan.	signed to challenge an				
		pice's response to and maintain				
	documentation of all of	drills, tabletop exercises, and				
	emergency events and	revise the hospice's emergency				
	plan, as needed.	500				
	*[For PRFTs at §441.]	184(d) Hospitals at				
	§482.15(d), CAHs at §					
		F, Hospital, CAH] must conduct				
	exercises to test the en	nergency plan twice per year.				
	The [PRTF, Hospital,	CAH] must do the following:				
		nnual full-scale exercise that is				
	community-based; or					
		ty-based exercise is not				
	accessible, conduct an functional exercise; or	annual individual, facility-based				
	runctional exercise; of			3 - 1 - 2		

STATEMENT PLAN OF CO	T OF DEFICIENCIES AND ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		E SURVEY
		DENTITION NONDER.	A. BUILDING	3	COM	PLETED
		34G237	B. WING			
NAME OF	PROVIDER OR SUPPLIER		Sec.	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/06/2023
				301 ERKWOOD DRIVE		
PINEBR	OOK GROUP HOME			HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAC		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
TREFIX IA		Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DE	BE FICIENCY)	COMPLETION DATE
E 039			E 039			
	Continued From page	0				
	(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires					
	activation of the emergency plan, the [facility] is					
	exempt from engaging in its next required full-scale					
		individual, facility-based				
	emergency event.	llowing the onset of the				
		additional] annual exercise or and				
	that may include, but	is not limited to the following:				
		-scale exercise that is				
	functional exercise; of	ndividual, a facility-based				
	(B) A mock disas	The second secon				
	(C) A tabletop ex	ercise or workshop that is led by				
	a facilitator and include	des a group discussion, using a				
	narrated, clinically-rel	levant emergency scenario, and a ents, directed messages, or				
	prepared questions de	signed to challenge an emergency				
	plan.	signed to chancinge an emergency				
	(iii) Analyze the [	facility's] response to and				
	maintain documentation	on of all drills, tabletop exercises,				
	emergency plan, as ne	and revise the [facility's]				
	emergency plan, as ne	eded.				
	*[For PACE at §460.8	4(d):]				
		organization must conduct				
	exercises to test the en	nergency plan at least annually.				
		on must do the following:				1
	community-based; or	mudi fun scale exclese that is				
		nunity-based exercise is not				1
	accessible, conduct an	annual individual, facility-based				
	functional exercise; or (B) If the PACE ex	xperiences an actual natural or				
		that requires activation of				
		volumes delivation of			2.0	
						1

STATEMENT PLAN OF CO	OF DEFICIENCIES AND PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		34G237	B. WING		12.	06/2023
	PROVIDER OR SUPPLIER  OOK GROUP HOME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	12/	00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROPRIATE	LD BE	(X5) COMPLETION DATE
E 039			E 039			
	engaging in its next r based or individual, f following the onset o	the PACE is exempt from equired full-scale community acility-based functional exercise of the emergency event. In the emergency event of the exercise every 2 years full-scale or functional exercise every 2 years full-scale or functional exercise of the exercise that is conducted is not limited to the following: the exercise that is individual, a facility based or (B) A mock disaster drill; which is led by a set of a group discussion, using a levant emergency scenario, and ments, directed messages, or esigned to challenge an analyze the PACE's response to ontation of all drills, tabletop of the exercise the entitle of the emergency of the emergency of facility, ICF/IID] must do the entitle of the emergency of facility, ICF/IID] must do the entitle of the exercise is not annual individual, facility-based ocility] facility experiences an equipment of the emergency of the exercise is not annual individual, facility-based ocility] facility experiences an				

STATEMENT PLAN OF CC	OF DEFICIENCIES AND PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G		E SURVEY PLETED
		34G237	B. WING		12.	/06/2023
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	12/	00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAC	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIAT	OULD BE	(X5) COMPLETION DATE
E 039			E 039			
	facility is exempt from full-scale community based functional exerememergency event. (ii) exercise that may incle following: (A) A secon community-based or a functional exercise; or (C) A tabletop exercise facilitator includes a guarrated, clinically-reset of problem statement prepared questions demergency plan. (iii) Analyze the [LTC and maintain document exercises, and emerge [LTC facility] facility'  *[For ICF/IIDs at §48 (2) Testing. The ICF/IID must do to (i) Participate in an an community-based; or (A) When a community-based; or (B) If the ICF/IID man-made emergency emergency plan, the ICF/IID man-made emergency emergency plan, the ICF in its next required full	the emergency plan, the LTC mengaging its next required a based or individual, facilitycise following the onset of the Conduct an additional annual lude, but is not limited to the ond full-scale exercise that is an individual, facility based or (B) A mock disaster drill; or see or workshop that is led by a group discussion, using a levant emergency scenario, and a ents, directed messages, or signed to challenge an  C facility] facility's response to nation of all drills, tabletop ncy events, and revise the semergency plan, as needed.  3.475(d)]:  ID must conduct exercises to test least twice per year, the following: nual full-scale exercise that is nunity-based exercise is not annual individual, facility-based experiences an actual natural or that requires activation of the CF/IID is exempt from engaging l-scale community-based or ed functional exercise following				

STATEMENT PLAN OF CO	OF DEFICIENCIES AND PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	The second of th	E SURVEY PLETED
		34G237	B. WING		12	/06/2023
	PROVIDER OR SUPPLIER  OOK GROUP HOME		1 3	STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	12/	700/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DE	) BE	(X5) COMPLETION DATE
E 039			E 039			
	include, but is not lim second full-scale exer or an individual, facil or (B) A mock disaste (C) A tabletop exercis facilitator and include narrated, clinically-re a set of problem states prepared questions de emergency plan. (iii) to and maintain docur exercises, and emerge ICF/IID's emergency *[For HHAs at §484.1] (d)(2) Testing. The HI test the emergency plamust do the following (i) Participate in community-based; or (A) When a commaccessible, conduct an based functional exercises (B) If the HHA exeman-made emergency emergency plan, the Hits next required full-sindividual, facility bas following the onset of (ii) Conduct an acopposite the year the first required full-sindividual for the proposite the year the first required for the proposite the	onal annual exercise that may sitted to the following: (A) A crise that is community-based ity-based functional exercise; or drill; or see or workshop that is led by a se a group discussion, using a levant emergency scenario, and ments, directed messages, or signed to challenge an Analyze the ICF/IID's response mentation of all drills, tabletop incy events, and revise the plan, as needed.  [02]  HA must conduct exercises to an at least annually. The HHA:  a full-scale exercise that is  [10]  HA is exempt from engaging in cale community-based or ed functional exercise the emergency event. Iditional exercise every 2 years, all-scale or functional exercise (i) of this section is conducted,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING	3	COM	LETED
		34G237	B. WING		12.	06/2022
NAME OF	PROVIDER OR SUPPLIER	39000		STREET ADDRESS, CITY, STATE, ZIP CODE	12/	06/2023
PINEBR	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TA		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
TREFIX IA		Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DE	BE FICIENCY)	COMPLETION DATE
E 039	Continued From page	e 12 limited	E 039			
	to the following:					
		l-scale exercise that is				
	functional exercise; or	an individual, facility-based				
	(B) A mock disas					
		ercise or workshop that is led by			-	
	a facilitator and include	des a group discussion, using a				
	narrated, clinically-re	levant emergency scenario, and a ents, directed messages, or				
	prepared questions de	signed to challenge an emergency				
	plan.					
	(iii) Analyze the HHA	's response to and maintain				
		drills, tabletop exercises, and drevise the HHA's emergency				
	plan, as needed.	are the third emergency				
	*[For OPOs at §486.3 (d)(2) Testing. The OF the emergency plan. T (i) Conduct a paper-ba workshop at least annuby a facilitator and inca narrated, clinically reand a set of problem stor prepared questions emergency plan. If the natural or man-made e activation of the emerg from engaging in its nefollowing the onset of Analyze the OPO's resudocumentation of all tasks.	PO must conduct exercises to test the OPO must do the following: used, tabletop exercise or utility. A tabletop exercise is led bludes a group discussion, using elevant emergency scenario, tatements, directed messages, designed to challenge an OPO experiences an actual emergency that requires gency plan, the OPO is exempt ext required testing exercise the emergency event. (ii) ponse to and maintain abletop exercises, and revise the [RNHCI's and				

	STATEMENT OF DEFICIENCIES AND PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	J		
		34G237	B. WING		12/06/2023	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	00/2023
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG		Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DE	BE FICIENCY)	COMPLETION DATE
E 039			E 039			
	Continued From page *[RNCHIs at §403.7. (d)(2) Testing. The RI test the emergency pla following: (i) Conduct a pa least annually. A table discussion led by a fa clinically-relevant em problem statements, d questions designed to (ii) Analyze the I maintain documentati emergency events, and plan, as needed. This STANDARD is Based on record revie failed to conduct exerc preparedness plan (EP  Review of the facility full-scale or communi  Interview with the fac there has not been a fu exercise nor a tabletop knowledge. PROTECTION OF CI CFR(s): 483.420(a)(3)  The facility must ensu Therefore, the facility individual clients to ex the facility, and as citiz including the right to f due process.	A8]: NHCI must conduct exercises to an. The RNHCI must do the  per-based, tabletop exercise at etop exercise is a group cilitator, using a narrated, regency scenario, and a set of directed messages, or prepared challenge an emergency plan. RNHCI's response to and on of all tabletop exercises, and do revise the RNHCI's emergency mot met as evidenced by:  we wand interview, the facility cises to test the emergency et annually. For example,  EPP revealed no evidence of a ty-based training exercise.  illity administrator confirmed that all-scale or community- based of exercise or mock drill to her  LIENTS RIGHTS	W 125	RHA Health Services will ensure the fac in compliance with all CMS guidelines in regard to Employee Training as it relates clients rights. IDT Team will ensure that employees have appropriate training require before working directly with clients and training is up to date on an ongoing basis Administrator/Program manager will Instaff on clients rights with an emphasis of freedom of movement. IDT team will ensure that the state of	n to all uired ensure s. ervice n	
				compliance by doing 2 interaction assess a week for 60 days then on an ongoing ba		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	G	COM	FLETED
		34G237	B. WING		12	/06/2023
NAME OF	PROVIDER OR SUPPLIER	7		STREET ADDRESS, CITY, STATE, ZIP CODE	12.	70072023
PINEBR	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECT PREFIX TAG (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROPRIATE		LD BE	(X5) COMPLETION DATE
W 125			W 12	5		
	facility failed to ensure were protected with respect to privacy finding is:  During observations is group home throughout 12/6/23, client #6 was and walk around the chome. Each time client told him to sit down. It redirected client #6 to the limit of	rvations and interviews, the re the rights of 1 of 6 clients (#6) espect to freedom of movement in e finding is:  In the vocational program and ut the survey on 12/5/23 and sobserved to attempt to get up lay placement and the group at #6 stood up and walked, staff At times, staff physically sit in a chair or on the couch.  With the facility administrator ecialist confirmed that client #6 e freely around his environment.  LIENTS RIGHTS  The the rights of all clients.  must ensure privacy during	W 130		elines in lates to that all required and going er will an n will	

STATEMENT OF DEFICIENCIES AND PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		DENTIFICATION NOT BEEK.	I .	Ĵ	COM	PLETED	
		34G237	B. WING		12/06/2022		
NAME OF I	PROVIDER OR SUPPLIER		1 :	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/06/2023	
PINEBRO	OOK GROUP HOME		301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	REGULATORY OR LS	Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE D	D BE DEFICIENCY)	COMPLETION DATE	
W 130			W 130				
	Continued From page	: 15					
		ivacy during care and treatment.					
W 186			W 186				
	CFR(s): 483.430(d)(1	-2)		is in compliance with all CMS guide			
	The facility must prov	vide sufficient direct care staff to		regard to appropriate staffing levels.	IDT team		
	manage and supervise	e clients in accordance with their		will ensure appropriate levels of staff times. Staffing coordinator has been			
	individual program pl	ans.		place to ensure that client staff ratio			
	Direct care staff are d	efined as the present on-duty staff		state guidelines. Administrator will re			
	calculated over all shi	fts in a 24-hour period for each		schedule weekly to ensure compliance	e for 60		
	defined residential liv			days.			
		not met as evidenced by: Based nterviews, the facility failed to					
		et care staff were available to					
	manage and supervise	6 of 6 clients in the home (#1,					
	#2, #3, #4, #5 a #6) in program plans. The fire	accordance with their individual					
	Observations in the gr	oup home on 12/6/23 at 6:30 AM on duty and supervising all 6					
	clients in the home (#	1, #2, #3, #4, #5, and #6).					
	Continued observation	revealed that client #3 was				1	
		s bed. Further observation rrived to the group home at 7:50					
		e group home at 7:53 AM.					
	Subsequent					1	
	observations revealed	that Staff B began passing					
	the medication room v	M, at which point Staff B was in with client #6 and surveyor with					
	the door closed and no	other staff present in the home.					
	Additional observation	as revealed that the alarm on					
		or alerted at 8:07 AM, while					
		medication room and no other					
	staff were present. At t	hat time, Staff B					
						1	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G237	B. WING				
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	12/	/06/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DEFI	E CIENCY)	(X5) COMPLETION DATE	
W 186			W 186				
W 249	of the room or see clireturn to his bedroom  Review of records for centered plan (PCP) of he requires line of sig absconding behavior. revealed current phys #3 and client #4 which or mechanical transfer all activities of daily l  Interview with the fact group home was not we client ratio based on its between 6:30 AM and PROGRAM IMPLEM CFR(s): 483.440(d)(1).  As soon as the interdisclient's individual progreceive a continuous a consisting of needed in sufficient number and	n room door, but did not go out ent #2, and directed client #2 to  client #2 revealed a person- lated 4/11/23 which indicates that ht supervision due to a history of Continued review of records ical therapy evaluations for client in indicated they require 2-peson and are dependent on staff for iving.  ility administrator confirmed the within the appropriate staff to dentified needs of the facility 8:18 AM on 12/6/23.  IENTATION  ciplinary team has formulated a gram plan, each client must ctive treatment program interventions and services in frequency to support the jectives identified in the	W 249	RHA Health Services will ensure the far is in compliance with all CMS guideline RHA will audit Pinebrook's PCP's within days and update them as needed to bring back into compliance. RHA will audit the PCP's on an ongoing basis through our biannual review process and again with cannual QA review.	n 60 g them		
188	on observations, record facility failed to ensure	not met as evidenced by: Based d reviews and interviews, the e clients received a continuous am consisting of needed ces					

	STATEMENT OF DEFICIENCIES AND (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G237	B. WING	3			
NAME OF	PROVIDER OR SUPPLIER	L	L	CTREET ADDRESS GITY STATE AT SORT	12/	/06/2023	
	OOK GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE  301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIAT	OULD BE	(X5) COMPLETION DATE	
W 249			W 249				
	Continued From page	17					
	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:						
	on 12/5/23 and 12/6/2 without the Angel Wat whenever client #2 lea observation revealed c alone 1t 5:33 PM on 1 to leave the vocational	oup home and vocational center 3 revealed client #1 to be 1 to device which alerts staff 1 to se 2 to leave the group home 2 2 to leave the group home 2 to leave the trash and 1 center alone at approximately again to take items to the trash.					
	plan (PCP) dated 4/11 describes a history of c various caregivers and behaviors in order to a	2/23 revealed a person-centered 2/23 for client #2 which client #2 absconding from displaying opportunistic void detection. Continued that the PCP calls for the use of					
	a watch device which is and notifies staff when	nonitors client #2's movements he has left an area of states that this device is to be					
	client #2's PCP is curre	lity administrator confirmed that nt, and that staff should ensure g the Angel Watch device for king hours.					
	B. The facility fai activities or implement	led to provide meaningful training objectives for					

STATEMENT PLAN OF CO	OF DEFICIENCIES AND PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		34G237	B. WING			
	PROVIDER OR SUPPLIER  OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP C 301 ERKWOOD DRIVE HENDERSONVILLE, NC 2879	CODE	/06/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO THE APPR	ION SHOULD BE	(X5) COMPLETION DATE
W 249			W 249			
	Continued From page					
	client #3 during large time. For example:	amounts of unstructured leisure				
	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.					
	AM until 8:50 AM revawake and drinking from the staff used a 2-person lead to his wheelchair, living room in front or remained until 9:15 A breakfast in the dining to the living room in fend of the observation observation revealed swith client #3 during to	oup home on 12/6/23 from 6:30 evealed client #3 to be in his bed from a baby bottle. At 8:50 AM, lift to move client #2 from his then placed client #3 in the f the television, where he M. Client #3 then ate his groom before staff returned him front of the television until the at 9:30 AM. Further staff had minimal interaction that same period and did not referred items or activities.				
	dated 7/31/23 which in tablet games, music, b learning toys. Continu	5/23 revealed a PCP for client #3 ndicates that client #3 enjoys oard games, and interactive ed record review revealed a tive to say the names of shapes e				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	± 2	I :	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/06/2023
PINEBRO	OOK GROUP HOME		l I	HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE D	D BE	(X5) COMPLETION DATE
W 249			W 249		<u> </u>	
	Continued From pa	ge 19 of				
	client #3's PCP is cur client #3 to access hi	cility administrator confirmed that rent, and that staff should assist s preferred items and activities tly train client #3's goals and				
	or implement training	to provide meaningful activities g objectives for client #6 during tructured leisure time. For				
	client #6 to be seated television which was observation revealed situation from 4:30 P dinner in the dining r his meal, client #6 was not allowed to go observation revealed from the couch and st to sit back down until take a shower. Subsect when client #5 return he was again directed	in the living room facing the playing a movie. Continued client #6 to remain in that M until 5:00 PM, when he ate his oom. Immediately after finishing as directed to sit on the couch and to to his bedroom. Further client #6 to repeatedly get up that to repeatedly direct client #5 is 5:55 PM, when client #6 went to quent observation revealed that ed from the shower at 6:08 PM, to sit on the couch and remained observations at 6:30 PM.				
	client #6 to be out of to be directed by staff to be called into the n observation revealed room at the direction	roup home on 12/5/23 revealed bed and dressed at 7:56 AM, and sto sit in a specific chair and wait nedication room. Continued client #6 to be seated in the living of staff from 8:18 AM until the vations at 9:30 AM, except for 10				

PLAN OF CO	OF DEFICIENCIES AND RRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				NG			
		34G237	B. WING _		12	/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	- 10 To 10 T		STREET ADDRESS, CITY, STATE, ZIP CODE		100/2023	
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY		(X5) COMPLETION DATE	
W 249			W 24	9			
		e 20 In he ate breakfast in the dining ations revealed that every time					
	client #6 attempted to redirected him to sit be client #6 went to the was, again, told to sit observations revealed schedule with client #	o get up from the couch, staff back down. On one occasion, kitchen and requested coffee and down and wait for it. Additional I that no staff used a visual to at any time during the or was one visible in the group					
	dated 11/15/23 which washing hands after to hygiene with staff assoutings twice per more closet, making his becwith staff assist. The laroutinely structure clipictures displayed on prompt, 'check your sethrough his daily rout	includes goals of thoroughly oileting, participating in oral aist, participating in community onth, hanging up to 5 shirts in his d, and making his morning coffee PCP further states, "Staff should ent #6's day, via a series of a board. Staff should use the chedule,' to assist client #6 ine. Seek to incorporate aities and items into daily routine, e."					
	#6 communicates with	on 12/5/23 revealed that client a staff mostly by pointing and communication tool available in				1	
	that client #6's PCP is confirmed that staff sh visual schedule as part they should offer clien	nt with preferred leisure	,				

	STATEMENT OF DEFICIENCIES AND (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G237	B. WING	- New	12.	/06/2023	
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	1 12	00,2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DE	BE	(X5) COMPLETION DATE	
W 249	Continued From page identified objectives		W 249				
W 440	CFR(s): 483.470(i)(1  at least quarterly for or This STANDARD is Based on record revifailed to ensure evacu quarterly for each shi  A review of the facility revealed that between conducted 12 fire drill occurred on third shift between 9:00 AM and Interview with the face	each shift of personnel. Into the met as evidenced by:  ew and interview, the facility pation drills were held at least fit of personnel. The finding is:  ty fire drill reports on 12/5/23 in 12/1/22 and 11/3/23, the facility les, but that of those, only one it. All other drills were conducted in 4:02 PM.  Callity administrator on 12/6/23 hould have been conducted	W 440	RHA Health Services will ensure the fain compliance with all CMS guidelines related to Emergency plans and supplied. Team will ensure all Evacuation Drill trare done correctly and with all current sas new staff are hired. All Drills will be returned and tracked at the main office as leaving a copy at the group home. All and RTL will be in-serviced on Emerged Drill's. Fire drills will be audited month corporate safety meeting for 3 months.	as s. IDT rainings taff and as well I DSP's		
	developmental level of This STANDARD is on observations, record facility failed to serve the developmental levelients (#2, #3, #5 and observed. The finding A. The facility failed client #2. For example Observations in the grant of the server of the serve	in a form consistent with the of the client.  not met as evidenced by: Based of review, and interviews, the food in a form consistent with els and prescribed diets of 4 of 6 #6) during 2 out of 2 meals are:  to ensure the prescribed diet for	1 -	RHA Health Services will ensure the faction compliance with all CMS guidelines. Spec will Inservice appropriate meal time guidelines as it relates to food consistent team will ensure compliance by doing bit meal time assessments for 60 days and of ongoing basis moving forward.	Hab e cy. IDT weekly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		LETED	
		34G237	B. WING _				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		/06/2023	
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	,		
		ATTEMENT OF DEPLOYED VOTES					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TA	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE APPROPR	SHOULD BE	(X5) COMPLETION DATE	
W 474			W 47	4			
			W47				
	beans, and rice pilaf. staff to serve a whole rice pilaf to client #2,	22 chicken pot pie, green Continued observations revealed pot pie, whole green beans and and client #2 to consume all tting up or modifying the food					
	Observations on 12/6/23 revealed the breakfast meal to consist of oatmeal, sliced bacon and toast. Continued observations revealed staff to serve oatmeal and whole slices of bacon to client #2, and client #1 to consume all items without staff cutting up or modifying the bacon in any manner.						
		(PCP) for client #2 dated 4/1/23 s currently on a regular diet and					
		cility Administrator confirmed and bacon should have been stency.					
	B. The facility failed client #3. For example	to ensure the prescribed diet for					
	serve a whole pot pie, and rice pilaf to client	me dinner meal revealed staff to whole green beans #3, and client #3 to consume all ting up or modifying the food in					
	revealed staff to serve slices of bacon to clien	23 of the same breakfast meal a whole slice of toast and whole at #3, and client #3 to consume cutting up or modifying the food					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:  34G237		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G237	B. WING	- Section -	12	/06/2023
	PROVIDER OR SUPPLIER  OOK GROUP HOME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	12/	00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE D	D BE	(X5) COMPLETION DATE
W 474			W 474			
	Continued From page	e 23				
	plan (PCP) for client client #3 is currently 1/2" consistency for a Interview with the Fa that client #3 should be consistency diet for a C. The facility failed client #5. For exampl Observations of the saserve a whole pot pie, and rice pilaf to client items without staff curany manner.  Observations on 12/6/2 revealed staff to serve bacon to client #5, and without staff cutting uranner.  Record review on 12/5 plan (PCP) for client #5 is currently corequires ground consistency diet for all c	to ensure the prescribed diet for e:  ame dinner meal revealed staff to whole green beans  #5, and client #5 to consume all tting up or modifying the food in  23 of the same breakfast meal oatmeal and whole slices of d client #5 to consume all items p or modifying the food in any  5/23 revealed a person-centered 4 dated 5/29/23 stating that on a heart healthy diet and stency for all foods.  cility Administrator confirmed ave been provided with a ground I foods.				
	D. The facility failed t client #6. For example	o ensure the prescribed diet for :				
						_

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:  34G237			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
		34G237					
NAME OF PROVIDER OR SUPPLIER PINEBROOK GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE  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 CROSS-REFERENCED TO THE APPROPRIATE DEF	ULD BE COMPLETION		
W 474	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 474				