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	34G237	A. BUILDING _____ B. WING _____	01/08/2025

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
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] 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) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037	(E 037) QP will provide in-service training to support staff and house manager in Emergency Preparedness Policies and Procedures. This will be monitored by the QP reviewing the Emergency Preparedness Policies and Procedures at each house meeting. In the future, the QP will ensure that support staff are knowledgeable of the Emergency Preparedness protocol. RECEIVED JAN 27 2025 DHSR-MH Licensure Sect	3/8/2025

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

DR. K. Ryder-Gross | Regional Director of Operations | 1/22/25

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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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 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 training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all 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. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		3/8/2025

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E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide 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.	E 037		3/8/2025

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		3/8/2025

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E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide 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, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness Plan (EPP) at least biennially. The finding is: Review of the facility's EPP on 1/8/25 revealed it was updated on 1/7/25. Continued review revealed no evidence of initial or biennial staff training on the EPP. Interview with the qualified intellectual disability professional on 1/8/25 confirmed that initial and biennial training for current staff has not been completed.	E 037		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 1 out of 6 clients (#3) was	W 125	(W 125) Hab. Specialist and QP will in-service the support staff and house manager about the protection of client rights and the importance of treating our individuals with dignity and respect. The clinical team is in process of ordering leather couches for Pinebrook in addition will explore furniture coverings that will keep the future clean but also show the individuals dignity and respect. To ensure dignity and respect is followed in regard to incontinence,	3/8/25

	the clinical team will complete monthly environmental assessments. In the future, QP will ensure people supported are treated with dignity and respect.	

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W 125	Continued From page 5 treated with dignity and respect regarding the use of incontinence padding. The finding is: During observations in the home on 1/7/25 and 1/8/25 client #3 was observed sitting on a living room couch with an incontinence pad clearly visible under the client's body. Further observation revealed an incontinence pad sitting on another couch in the living room. Interviews with the qualified intellectual disability professional (QIDP) and Home Supervisor on 1/7/25 and 1/8/25 revealed that the purpose of the incontinence pads is to prevent damage to furniture and equipment from toileting accidents. Further interview confirmed that use of the incontinence pads violates the clients' right to dignity.	W 125	
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 and interview, the facility failed to ensure 4 of 6 clients (#2, #3, #4, #6) received a continuous active treatment program consisting of needed interventions. The finding is:	W 249	

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W 249	Continued From page 6 Observations in the group home on 1/7/25 revealed clients #2 and #4 to utilize a wheelchair and require full assistance from staff. Continued observations from 4:00 PM to 5:15 PM revealed clients #2 and #4 to remain idol and unengaged in the living room. Observations of client #3 from 4:00 PM to 5:15 PM revealed them to ambulate independently throughout the home and remain unengaged in any formal or informal active treatment. Observations of client #5 from 4:00 PM to 5:15 PM revealed them to ambulate independently and attempt to engage with staff. Continued observations revealed staff to continuously redirect client #5 to sit down on the couch and "show me wait" until the dinner meal was ready. Observations in the group home on 1/8/25 at 7:00 AM revealed clients #2 and #4 to be sitting in the living room. Continued observations from 7:00 AM to 7:58 AM revealed client #2 to remain idol and unengaged in the living room. Further observations at 7:30 AM revealed client #4 to be offered a puzzle at the kitchen table. Observations of client #3 from 7:00 AM to 7:58 AM revealed them to ambulate independently throughout the home and remain unengaged in any formal or informal active treatment. Interview with the qualified intellectual disability professional on 1/8/25 confirmed clients should be engaged at all opportunities to promote progress towards the achievement of goals and objectives.	W 249	(W 249) Hab. Specialist will in-service support staff and house manager on active treatment to all people supported including those in wheelchairs. The Hab. Specialist will explore and incorporate meaningful activities through a consistent schedule for the people supported at home and once they return to the vocational center. This will be monitored by the clinical team completing two interaction assessments weekly for a period of one month, then on a routine basis. In the future, the QP will ensure that all people supported are involved in active treatment.	3/8/2025
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature.	W 473		

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W 473	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all foods were served at an appropriate temperature for 6 of 6 clients. The finding is: Observations upon entering the group home on 1/7/25 at 4:00 PM revealed two Papa John's pizza boxes on the kitchen counter. Interview with the home manager confirmed the clients are having pizza for dinner. Continued observations at 4:30 PM revealed the pizza boxes to be placed in the oven, and for the oven to be off. Further observations at 5:18 PM revealed all clients to be served pizza for dinner without it being reheated. Interview with the qualified intellectual disability professional on 1/8/25 confirmed staff should have reheated the pizza prior to serving clients the dinner meal.	W 473	(W 473) Hab. Specialist will in-service support staff and house manager about making sure that foods are served at appropriate temperatures. This will be monitored by the clinical team completing two meal assessments weekly for a period of one month, then on a routine basis. In the future, QP will ensure that all foods served to people supported are served at appropriate temperatures.	3/8/2025
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to serve food in a form consistent with the developmental levels and prescribed diets of 5 of 6 clients (#1, #2, #3, #5, and #6). The findings are: A. The facility failed to ensure the prescribed diet for client #1. For example: Observations in the group home on 1/7/25 at 5:20 PM revealed the dinner meal to be pizza and fruit cups. Continued observation revealed staff to	W 474	(W 474) Hab. Specialist will in-service support staff and house manager on diet consistencies per resident developmental needs. This will be monitored by the clinical team completing two meal assessments weekly for a period of one month, then on a consistent basis. In the future, QP will ensure that all residents are consuming foods prepared with appropriate consistencies according to their developmental needs.	3/8/2025

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serve client #1 pizza which was cut into large chunks, requiring client #1 to eat them in more than one bite. Further observation revealed client #1 to consume his meal without further modification or assistance from staff.

Observations in the group home on 1/8/25 at 8:20 AM revealed the breakfast meal to be instant oatmeal, hash brown patties and applesauce. Continued observation revealed staff to serve client #1 hash brown patties which were cut into pieces of approximately 1". Further observation revealed client #1 to consume all of this meal.

Record review on 1/8/25 revealed a nutritional evaluation for client #1 dated 9/25/24 stating that the client is currently on a heart healthy diet and requires food to be cut to 1/2" consistency.

Interview on 1/8/25 with the qualified intellectual disability professional (QIDP) confirmed that client #1's diet order is current and that his food should have been cut to ½" consistency for the client's safety.

B. The facility failed to ensure the prescribed diet for client #2. For example:

Observations in the group home on 1/7/25 at 5:20 PM revealed the dinner meal to be pizza and fruit cups. Continued observation revealed staff to serve client #2 pizza which was cut into large chunks, requiring client #2 to eat them in more than one bite. Further observation revealed client #2 to consume his meal without further modification or assistance from staff.

Record review on 1/8/25 revealed a nutritional evaluation for client #2 dated 9/25/24 stating that

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W 474	Continued From page 9 the client is currently on a heart healthy diet and requires food to be cut to 1" consistency. Interview on 1/8/25 with the QIDP confirmed that client #2's diet order is current and that his food should have been cut to1" consistency for the client's safety. C. The facility failed to follow client #3's diet as ordered. For example: Observations in the group home on 1/7/25 at 5:20 PM revealed the dinner meal to be pizza and fruit cups. Continued observation revealed staff to serve client #3 pizza which was cut into large chunks, requiring client #3 to eat them in more than one bite. Further observation revealed client #3 to consume his meal without further modification or assistance from staff. Subsequent observation at 5:23 PM revealed client #3 to gag on his food to the point that staff had to reach into the client's mouth to remove large amounts of pizza. Record review on 1/8/25 revealed a nutritional evaluation for client #3 dated 12/2/24 stating that the client is currently on a heart healthy diet and requires food to be modified to 1/2" soft consistency, with extra protein portions, when possible, gluten and dairy free. Interview on 1/8/25 with the QIDP confirmed that client #3's diet order is current and that his food should have been modified to ½" soft consistency for the client's safety. D. The facility failed to follow client #5's diet as ordered. For example:	W 474	

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Observations in the group home on 1/7/25 at 5:20 PM revealed the dinner meal to be pizza and fruit cups. Continued observation revealed staff to serve client #5 pizza which was cut into large chunks, requiring client #5 to eat them in more than one bite. Further observation revealed client #5 to consume his meal without further modification or assistance from staff.

Observations in the group home on 1/8/25 at 8:20 AM revealed the breakfast meal to be instant oatmeal, hash brown patties and applesauce. Continued observation revealed staff to serve client #5 hash brown patties which were cut into pieces of approximately 1". Further observation revealed client #5 to consume all of this meal.

Record review on 1/8/25 revealed a nutritional evaluation for client #5 dated 9/26/24 stating that the client's current diet order is: heart healthy, weight gain diet, ground consistency, no caffeine, no grapefruit.

Interview on 1/8/25 with the QIDP confirmed that client #5's diet order is current and that his food should have been ground for the client's safety.

E. The facility failed to follow client #6's diet as ordered. For example:

Observations in the group home on 1/7/25 at 5:20 PM revealed the dinner meal to be pizza and fruit cups. Continued observation revealed staff to serve client #6 pizza which was cut into large chunks, requiring client #6 to eat them in more than one bite, as well as whole mandarin orange slices. Further observation revealed client #6 to consume his meal without further modification or assistance from staff. Subsequent observation at

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W 474	Continued From page 11 5:33 PM revealed client #6 to gag on his food. Observations in the group home on 1/8/25 at 8:20 AM revealed the breakfast meal to be instant oatmeal, hash brown patties and applesauce. Continued observation revealed staff to serve client #6 hash brown patties which were cut into pieces of approximately 1". Further observation revealed client #6 to consume all of this meal. Record review on 1/8/25 revealed a nutritional evaluation for client #6 dated 9/26/24 stating that the client is currently on a heart healthy diet and requires food to be cut to 1/4" consistency with nectar thick liquids. Interview on 1/8/25 with the QIDP confirmed that client #6's diet order is current and that his food should have been cut to 1/4" consistency for the client's safety.	W 474	