PRINTED: 01/10/2025 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		34G237	B. WING		01	/08/2025
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COI 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE 3/8/2025
	§441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §485 §485.727(d)(1), §485 §491.12(d)(1). *[For RNCHIs at §40 Hospitals at §482.15 at §484.102, REHs aunder §485.727, OP RHC/FQHCs at §49 (1) Training programenthe following: (i) Initial training in elepolicies and procedustaff, individuals programent, and voexpected roles. (ii) Provide emergencest every 2 years. (iii) Maintain docume preparedness training (iv) Demonstrate states procedures. (v) If the emergency procedures are signimust conduct training procedures. *[For Hospices at §4 hospice must do all (i) Initial training in empolicies and procedures, services under arrange expected roles.	6.54(d)(1), §418.113(d)(1), 0.84(d)(1), §482.15(d)(1), .475(d)(1), §484.102(d)(1), 5.542(d)(1), §486.360(d)(1), 5.920(d)(1), §486.360(d)(1), .5.920(d)(1), §486.360(d)(1), .6.920(d)(1), §486.360(d)(1), .9.3.748, ASCs at §416.54, .6. ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 1.12:] In. The [facility] must do all of mergency preparedness ures to all new and existing eviding services under plunteers, consistent with their cy preparedness training at entation of all emergency g. If knowledge of emergency preparedness policies and ficantly updated, the [facility] g on the updated policies and .18.113(d):] (1) Training. The	EO	(E 037) QP will provide in-service training and house manager in Emergency Prepared Procedures. This will be monitored by the Emergency Preparedness Policies and Prohouse meeting. In the future, the QP will er staff are knowledgeable of the Emergency protocol. RECEIVED JAN 27 2025 DHSR-MH Licensure Sec	ness Policies and Previewing the cedures at each sure that support y Preparedness	

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.

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

Event ID: HPBY11

Facility ID: 922389

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY MPLETED
		34G237	B. WING _		01/	08/2025
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE 3/8/2025
	procedures. (iii) Provide emerger least every 2 years. (iv) Periodically revie emergency prepared employees (including special emphasis plant procedures necessation of the secondary of the seco	fi knowledge of emergency ney preparedness training at ew and rehearse its dness plan with hospice g nonemployee staff), with aced on carrying out the ary to protect patients and entation of all emergency g. I preparedness policies and ificantly updated, the hospice g on the updated policies and .184(d):] (1) Training must do all of the following: mergency preparedness ures to all new and existing eviding services under lunteers, consistent with their g, provide emergency g every 2 years. If knowledge of emergency greparedness policies and ficantly updated, the PRTF g on the updated policies and entation of all emergency greparedness policies and ficantly updated, the PRTF g on the updated policies and entation of the updated policies and entation.	E 03			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		DATE SURVEY COMPLETED	
	10	34G237	B. WING		01/	08/2025	
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE 3/8/2025	
	staff, individuals pro arrangement, contra volunteers, consiste (ii) Provide emergen least every 2 years. (iii) Demonstrate sta procedures, includir what to do, where to case of an emergen (iv) Maintain docume (v) If the emergency procedures are sign must conduct trainin procedures. *[For LTC Facilities a Program. The LTC f following: (i) Initial training in expolicies and procedustaff, individuals pro arrangement, and voexpected role. (ii) Provide emergency least annually. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policies and existing staff, incompared to the contract of the	ures to all new and existing oviding on-site services under actors, participants, and ent with their expected roles. It with their expected roles are for with their expected roles. It with their expected roles are for go, and whom to contact in expectation of all training. It is preparedness policies and if icantly updated, the PACE go on the updated policies and at §483.73(d):] (1) Training acility must do all of the emergency preparedness ures to all new and existing oviding services under colunteers, consistent with their experiences training at entation of all emergency go. If knowledge of emergency estand procedures to all new dividuals providing services and procedures to all new dividuals providing services and volunteers, consistent	ΕO	37			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	TIPLE CONSTRUCTION			E SURVEY MPLETED
		34G237	B. WING			01/	08/2025
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COI 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	DΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD E	BE	COMPLETION DATE 3/8/2025
	least every 2 years. (iii) Maintain docume (iv) Demonstrate sta procedures. All new and assigned specific the CORF's emerge their first workday. include instruction in alarm systems and equipment. (v) If the emergence procedures are sign must conduct trainin procedures. *[For CAHs at §485.6] The CAH must do a (i) Initial training in expolicies and procedure procedures and where necessar personnel, and guest cooperation with fire authorities, to all new individuals providing and volunteers, constroles. (ii) Provide emergency least every 2 years. (iii) Maintain docume (iv) Demonstrate staff procedures. (v) If the emergency procedures are significations.	entation of the training. aff knowledge of emergency personnel must be oriented fic responsibilities regarding ncy plan within 2 weeks of The training program must a the location and use of signals and firefighting by preparedness policies and ificantly updated, the CORF g on the updated policies and lof the following: mergency preparedness program. Il of the following: mergency preparedness program. Il of the following: mergency preparedness program. Il of the following: mergency preparedness program. It is including prompt program. It is including prompt program to the program of fires, protection, y, evacuation of patients, ts, fire prevention, and fighting and disaster	EC	037			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	s.	34G237	B. WING		01/	/08/2025	
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE	
W 125	CMHC must provide preparedness policical and existing staff, in under arrangement, with their expected documentation of the demonstrate staff keyrocedures. Thereas emergency prepared years. This STANDARD is Based on record refailed to ensure direct the facility's Emerged (EPP) at least bienn Review of the facility was updated on 1/7/2 revealed no evidence training on the EPP. Interview with the querofessional on 1/8/2 biennial training for completed. PROTECTION OF COCFR(s): 483.420(a)(3) The facility must ensure the facility individual clients to end the facility, and as including the right to to due process. This STANDARD is Based on observations.	B5.920(d):] (1) Training. The e initial training in emergency es and procedures to all new ndividuals providing services and volunteers, consistent roles, and maintain he training. The CMHC must nowledge of emergency fter, the CMHC must provide dness training at least every 2 not met as evidenced by: view and interview, the facility of care staff were trained on ency Preparedness Planially. The finding is: 2's EPP on 1/8/25 revealed it is EPP on 1/8/25 revealed it is continued review e of initial or biennial staff alified intellectual disability confirmed that initial and current staff has not been LIENTS RIGHTS	E 0		e lient ng our t. The ing rings also		

		H AND HUMAN SERVICES E & MEDICAID SERVICES		FORM	0: 01/10/2025 MAPPROVED D. 0938-0391	
				the clinical team will complete environmental assessments. In future, QP will ensure people s are treated with dignity and res	the upported	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000-0000000000000000000000000000000000	TIPLE CONSTRUCTION DING		E SURVEY PLETED
		34G237	B. WING		01/0	08/2025
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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		D BE	COMPLETION DATE

W 125		page 5 y and respect regarding the use adding. The finding is:	W 12	25		
	1/8/25 client #3 wa room couch with a visible under the c	ns in the home on 1/7/25 and as observed sitting on a living an incontinence pad clearly slient's body. Further led an incontinence pad sitting in the living room.				
W 249	professional (QIDI 1/7/25 and 1/8/25 the incontinence p furniture and equip Further interview of		W 24			
	formulated a client each client must re treatment program interventions and s and frequency to se	erdisciplinary team has 's individual program plan, eceive a continuous active consisting of needed services in sufficient number upport the achievement of the ed in the individual program				
	Based on observat failed to ensure 4 or received a continuo	is not met as evidenced by: tions and interview, the facility of 6 clients (#2, #3, #4, #6) bus active treatment program and interventions. The finding is:				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY PLETED
		34G237	B. WING		01/0	08/2025
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE 3/8/2025

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 W 249 Continued From page 6 W 249 Observations in the group home on 1/7/25 (W 249) Hab. Specialist will in-service support staff revealed clients #2 and #4 to utilize a wheelchair and house manager on active treatment to all people 3/8/2025 and require full assistance from staff. Continued supported including those in wheelchairs. The Hab. observations from 4:00 PM to 5:15 PM revealed Specialist will explore and incorporate meaningful clients #2 and #4 to remain idol and unengaged activities through a consistent schedule for the people supported at home and once they return to the in the living room. Observations of client #3 from vocational center. This will be monitored by the 4:00 PM to 5:15 PM revealed them to ambulate clinical team completing two interaction assessments independently throughout the home and remain weekly for a period of one month, then on a routine unengaged in any formal or informal active basis. In the future, the QP will ensure that all people treatment. Observations of client #5 from 4:00 supported are involved in active treatment. 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 473 MEAL SERVICES W 473 CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G237 B. WING 01/08/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

PINEBROOK GROUP HOME

(X4) ID

PRFFIX

TAG

PREFIX

TAG

301 ERKWOOD DRIVE

HENDERSONVILLE, NC 28791

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X5)

COMPLETION

DATE

3/8/2025

1						
W 473	Based on observation failed to ensure a	page 7 is not met as evidenced by: ations and interviews, the facilit Il foods were served at an erature for 6 of 6 clients. The	W 47 y	73		
	1/7/25 at 4:00 PM pizza boxes on the the home manage having pizza for d at 4:30 PM revealed in the oven, and for observations at 5:	n entering the group home on revealed two Papa John's exitchen counter. Interview with r confirmed the clients are inner. Continued observations ed the pizza boxes to be placed or the oven to be off. Further 18 PM revealed all clients to be inner without it being reheated.	Γ	(W 473) Hab. Specialist will in-service su and house manager about making sure that served at appropriate temperatures. This w monitored by the clinical team completing assessments weekly for a period of one mo on a routine basis. In the future, QP will en all foods served to people supported are set appropriate temperatures.	foods are ill be two meal nth, then sure that	3/8/2025
W 474	professional on 1/	qualified intellectual disability 8/25 confirmed staff should pizza prior to serving clients)(2)(iii)	W 474	4		
	developmental leverage This STANDARD Based on observation interviews, the factorial consistent with the statement of the stat	is not met as evidenced by: tions, record review, and ility failed to serve food in a th the developmental levels and f 5 of 6 clients (#1, #2, #3, #5,	е	(W 474) Hab. Specialist will in-sesupport staff and house manage diet consistencies per resident developmental needs. This will be monitored by the clinical team completing two meal assessmen weekly for a period of one month on a consistent basis. In the future	er on be ts n, then	3/8/2025
	Observations in the PM revealed the d	d to ensure the prescribed diet xample: e group home on 1/7/25 at 5:20 inner meal to be pizza and fruit oservation revealed staff to		will ensure that all residents are consuming foods prepared with appropriate consistencies accordance their developmental needs.		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	DF CORRECTION	IDENTIFICATION NUMBER:		3		PLETED
		34G237	B. WING		01/0	8/2025
	PROVIDER OR SUPPLIER OOK GROUP HOME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 801 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		3/8/2025

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W 474	chunks, requiring than one bite. Furt #1 to consume his modification or as Observations in the AM revealed the boatmeal, hash brocontinued observations of approximate revealed client #1. Record review on evaluation for client the client is current requires food to both Interview on 1/8/25 disability profession client #1's diet ord should have been client's safety. B. The facility failer for client #2. For experiment of the province of the p	colient #1 to eat them in more ther observation revealed client and without further sistance from staff. The group home on 1/8/25 at 8:20 treakfast meal to be instant without matter and applesauce. The action revealed staff to serve with patties which were cut into mately 1". Further observation to consume all of this meal. 1/8/25 revealed a nutritional at #1 dated 9/25/24 stating that the cut to 1/2" consistency. The with the qualified intellectual and (QIDP) confirmed that he cut to 1/2" consistency for the docut to 1/2" consistency for the document the prescribed diet wample: The group home on 1/7/25 at 5:20 may be presented them in more the conservation revealed staff to the conservation revealed client meal without further sistance from staff.	W 47	4		
		t #2 dated 9/25/24 stating that				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		34G237			01/0	08/2025
PINEBRO	PROVIDER OR SUPPLIER OOK GROUP HOME		, i	BTREET ADDRESS, CITY, STATE, ZIP CODE BOT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE

W 474	Interview on 1/8/29 client #2's diet ord should have been	tage 9 tly on a heart healthy diet and be cut to 1" consistency. with the QIDP confirmed that ler is current and that his food cut to 1" consistency for the	W 4	74		
	client's safety. C. The facility faile ordered. For exam	ed to follow client #3's diet as				
	PM revealed the d cups. Continued o serve client #3 piz chunks, requiring of than one bite. Furt #3 to consume his modification or assobservation at 5:20 on his food to the page 1.5 continued in the page 2.5 continued in the p	e group home on 1/7/25 at 5:20 inner meal to be pizza and fruit bservation revealed staff to za which was cut into large client #3 to eat them in more her observation revealed client meal without further sistance from staff. Subsequen 3 PM revealed client #3 to gag point that staff had to reach into to remove large amounts of	t			
	evaluation for clien the client is current requires food to be	1/8/25 revealed a nutritional at #3 dated 12/2/24 stating that ally on a heart healthy diet and e modified to 1/2" soft extra protein portions, when and dairy free.				
	client #3's diet orde	with the QIDP confirmed that er is current and that his food modified to ½" soft consistency ety.				
	D. The facility failed ordered. For example	d to follow client #5's diet as ple:				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		34G237	Company of the second s		01/0	08/2025
	PROVIDER OR SUPPLIER DOK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/10/2025 FORM APPROVED

CENTERS FO	OR MEDICARI	E & MEDICAID SERVICES			OMB NO	. 0938-03
Observed churs than #5 to model of the control of t	revealed the distributed of the client #5 pizzenks, requiring on one bite. Furto o consume his diffication or as dervations in the revealed the beneal, hash browned the beneal hash browned the second of the client #5 pizzenks, requiring the client #6 pizzenks, requiring the continued of the client #6 pizzenks, requiring the client #6 pizzenks, requiring the continued of the client #6 pizzenks, requiring the client #6 pizzenks,	linner meal to be pizza and fruit observation revealed staff to be pizza and fruit observation revealed staff to be pizza and fruit observation revealed client #5 to eat them in more ther observation revealed client is meal without further sistance from staff. The group home on 1/8/25 at 8:20 reakfast meal to be instant without matter and applesance. The patties and applesance with patties and applesance with patties which were cut into mately 1". Further observation to consume all of this meal. The dated 9/26/24 stating that diet order is: heart healthy, round consistency, no caffeine, with the QIDP confirmed that her is current and that his food ground for the client's safety. The date of the client's safety with the QIDP confirmed that her is current and that his food ground for the client's diet as ple: The group home on 1/7/25 at 5:20 oner meal to be pizza and fruit observation revealed staff to be without mandarin orange are related to the mandarin orange are related to the mandarin orange are related to be pizza and fruit observation revealed client #6 to without further modification or aff. Subsequent observation at				
AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE COMP	
		34G237	B. WING _		01/0	8/2025
PINEBROOK G	ROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE

3/8/2025

DEFICIENCY)

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 W 474 Continued From page 11 W 474 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.