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	34G237	A. BUILDING _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK GROUP HOME	**301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791**

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W 000	INITIAL COMMENTS A complaint survey was completed on 4/1/25 for intake #NC00228224, #NC00228212, #NC00228216, #NC00228442, #NC00228541 and #NC00228594. The complaints were substantiated. A Condition of Participation in Client Rights, Condition of Participation in Dietetic Services and standard level deficiencies were cited.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its' clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure deceased client (dc #1) was not subjected to unintentional neglect. The findings is: Review on 4/1/25 of the facility's internal investigations revealed an investigation dated 3/17/25 and was conducted following the death of	W 149		

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

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W 149	Continued From page 1	W 149		

dc #1 to determine if staff followed the prescribed diet order after a choking incident in the home.

Further review of the investigation revealed on 3/17/25, Staff C prepared lunch consisting of chicken nuggets and baked beans. Based on Staff C's interview, she was on the phone and had been distracted while preparing lunch and told Staff A lunch was ready. Dc #1 was served whole chicken nuggets and baked beans.

Review on 4/1/25 of dc #1's record revealed a nutritional assessment dated 9/26/24. Continued review of the nutritional assessment revealed a diet order consisting of heart healthy, weight gain diet, ground consistency, no caffeine and no grapefruit.

Review on 4/1/25 of dc #1's physician's orders dated 12/8/24 revealed a diet order consisting of heart healthy, weight gain diet, ground consistency, no caffeine and no grapefruit.

Review of medical records dated 3/17/25 revealed dc #1 was eating lunch, began choking and became unresponsive. Emergency Management Services (EMS) was called. When EMS arrived, dc #1 was apneic, pulseless and intubation was initially unsuccessful even after removing three whole chicken nuggets and beans from his upper airway. At the time of arrival to the local hospital, dc #1 was declared deceased.

Interview on 4/1/25 with Staff A who is a fill in staff from a sister facility within the company revealed he was working on the day the choking incident happened. Staff A stated he assisted with serving lunch, but was not aware that dc #1 was on a ground consistency diet. Staff A reported he

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W 149	Continued From page 2 began working in the home on 3/7/25, and prior to the incident, he had not received client specific training. Interview on 4/1/25 with the facility administrator and regional administrator revealed that on the day of the incident, it was substantiated that Staff C was neglectful when she was on her personal phone talking while preparing lunch. That negligence resulted in dc #1 being served food in a whole consistency, resulting in a choking incident and his death. Review on 4/1/25 of the facility's policy 102.05 "Abuse, Neglect and Exploitation" revealed neglect as being defined as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm. Continued review of the policy revealed "unintentional neglect" is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk of harm. Further review of the facility's investigation, substantiated by interview with staff, revealed the facility had taken corrective action at the group home by training staff on client's diets orders and diet charts. However, in that the facility failed to assure staff were adequately trained and monitoring dc #1 to assure the client was given the required diet which resulted in the client's death, the facility was found to be negligent.	W 149		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with	W 189		

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W 189	Continued From page 3 initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in diet orders for dc #1. The finding is: Review on 4/1/25 of the facility's internal investigations revealed an investigation dated 3/17/25 and was conducted following the death of dc #1 to determine if staff followed the prescribed diet order after a choking incident in the home. Further review of the investigation revealed on 3/17/25, Staff C prepared lunch consisting of chicken nuggets and baked beans. Based on Staff C's interview, she was on the phone and had been distracted while preparing lunch and told Staff A lunch was ready. Dc #1 was served whole chicken nuggets and baked beans. Interview on 4/1/25 with Staff A revealed he has worked in the facility, along with Staff B, since 3/7/25. Staff A stated neither he or Staff B received any training on the client's diet orders prior to the incident on 3/17/25. Staff A reported that he and Staff B relied on other direct support professionals (DSP) in the home to give them information that was needed. Interview on 4/1/25 with the facility administrator and regional administrator revealed staff had been trained on dc #1's diet. Review of training rosters provided by the administrators did not reveal specific client diet orders training had occurred	W 189		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i)	W 340		

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W 340	Continued From page 4 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently follow medication administration procedures. This affected 1 of 1 audit clients (#1) observed during medication administration. The findings is: A. During observations in the home on 4/1/25 of the medication administration at approximately 8:00am, client #1 was called in the medication room. Staff B was observed handing client #1 a medication cup that contained medications she had already punched prior to the client entering the med room. During an immediate interview on 4/1/25 at 8:02am with staff B regarding what medications the client was receiving, staff B pulled client #1's medication box out the cabinet and handed surveyor medications that were bundled together with a rubberband. The medications in the bundle were as follows: Keppra 1000mg, Synthroid 75mcg, Losartan 100-25mg, Minoxidil 5mg, Olanzapine 5mg, Prilosec 20mg, Vitamin D3 2000IU. The client also received Refresh eye drops, Glucerna, and Chlorhexidine 15ml. Client #1 also received Tylenol 650mg after asking staff for the medication. Interview on 4/1/25 with the facility's nurse revealed all clients should be in the medication room prior to medications being punched and all	W 340		

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W 340	Continued From page 5	W 340		

clients should be given the opportunity to assist with their medication administration to the best of their capabilities.

B. During observations in the home on 4/1/25 of the medication administration at approximately 8:00am, client #1 was called in the medication room. Staff B was observed handing client #1 a medication cup that contained medications she had already punched prior to the client entering the medication room.

During an immediate interview on 4/1/25 at 8:02am with staff B regarding what medications the client was receiving, staff B pulled client #1's medication box out the cabinet and handed the surveyor medications that were bundled together with a rubberband. The medications in the bundle were as follows: Keppra 1000mg, Synthroid 75mcg, Losartan 100-25mg, Minoxidil 5mg, Olanzapine 5mg, Prilosec 20mg, Vitamin D3 2000IU. The client also received Refresh eye drops, Glucerna, and Chlorhexidine 15ml. Client #1 also received Tylenol 650mg after asking staff for the medication.

Further interview on 4/1/25 with staff B revealed that client #1 requests an as needed (PRN) medication every morning during medication pass of either Tylenol or Milk of Magnesia. Staff B revealed that after the medication pass is over, she will then document the PRN medication given in Therap.

Interview on 4/1/25 with the facility's nurse revealed that prior to any PRN medication being given, staff is supposed to call nursing first. The nurse confirmed she had not received a call about client #1 receiving Tylenol during

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W 340	Continued From page 6 medication pass on 4/1/25 nor had the medication been documented by staff B as having been given.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 1 audit clients (#1) observed during medication pass. The finding is: During observations of medication administration in the home on 4/1/25 at approximately 8:00am, Staff B called client #1 into the medication room and handed him a medication cup. Client #1 took the medications at 8:05am. During an immediate interview on 4/1/25 with Staff B, when asked what medications were being administered to client #1, Staff B pulled client #1's medication box out the cabinet and handed the surveyor medications that were bundled together with a rubberband. The medications in the bundle were as follows: Keppra 1000mg, Synthroid 75mcg, Losartan 100-25mg, Minoxidil 5mg, Olanzapine 5mg, Prilosec 20mg, Vitamin D3 2000IU. The client also received Refresh eye drops, Glucerna, and Chlorhexidine 15ml. Client #1 also received Tylenol 650mg after asking staff for the medication. . Review on 4/1/25 of client #1's physician's orders dated 3/7/25 revealed client #1 should receive	W 369		

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W 369	Continued From page 7 Levothyroxin 75mcg 30 minutes prior to breakfast or other medications, Omeprazole 20mg on Monday, Wednesday, Friday and Saturday and Chlorhexidine 15ml at bedtime. Further observations in the home on 4/1/25 at 8:25am, client #1 began eating breakfast. Interview on 4/1/25 with the facility nurse confirmed client #1 should not have been administered Levothyroxin with other medications and client #1 should have waited 30 minutes after consuming his medication to eat breakfast. The nurse confirmed Prilosec should not have been given on 4/1/25 as it was a Tuesday and Chlorhexidine should be administered at 8pm and should not have been given during morning medication pass.	W 369		
W 459	DIETETIC SERVICES CFR(s): 483.480 The facility must ensure that specific dietetic services requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure dc #1 and 2 of 6 audit clients (#1 and #3) observed eating lunch received their modified and specially-prescribed diets (W460). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services.	W 459		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

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Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to provide a modified and specially-prescribed diet for dc #1 and 2 of 6 audit clients (#1 and #3) observed eating lunch. The findings are:

A. Review on 4/1/25 of the facility's internal investigation dated 3/17/25 revealed an investigation was conducted following the death of dc #1 to determine if staff followed the prescribed diet order after a choking incident in the home.

Further review of the investigation revealed on 3/17/25, Staff C prepared lunch consisting of chicken nuggets and baked beans. Based on Staff C's interview, she was on the phone and distracted while preparing lunch and told Staff A lunch was ready. Dc #1 was served chicken nuggets and baked beans in whole form.

Review of dc #1's record revealed a nutritional assessment dated 9/26/24. Continued review of the nutritional assessment revealed a diet order consisting of heart healthy, weight gain diet, ground consistency, no caffeine and no grapefruit.

Review on 4/1/25 of dc #1's physician's orders dated 12/8/24 revealed a diet order consisting of heart healthy, weight gain diet, ground consistency, no caffeine and no grapefruit.

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Interview on 4/1/25 with the facility administrator and regional administrator revealed that on the day of the incident, it was substantiated that Staff C was neglectful when she was on her personal phone talking while preparing lunch, which resulted in dc #1 being served food in a whole consistency, resulting in a choking incident and his death.

B. Observations in the home on 4/1/25 at 8:26am revealed client #3 eating breakfast, which consisted of french toast sticks and sausage, served in 1" pieces in size, with all food served on his plate.

Review on 4/1/25 of client #3's record revealed a person-centered plan (PCP) dated 3/20/25. Continued review of the PCP revealed a diet order consisting of 1/2" consistency, client to be given 4 - 6 bites at a time to slow eating rate and limit overstuffing his mouth.

Interview on 4/1/25 with the Habilitation Specialist (Hab Spec) and facility nurse revealed client #3's diet order is current, and he should have been served food in 1/2" consistency and only given 4 - 6 pieces of food at a time.

C. Observations in the home on 4/1/25 at 8:26am revealed client #1 eating breakfast, which consisted of 5 whole french toast sticks and sausage.

Review on 4/1/25 of client #1's nutritional assessment dated 9/25/24 revealed a diet order consisting of heart healthy diabetic diet, whole consistency, regular liquids and no concentrated sweets.

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W 460	Continued From page 10 Review of the facility's diet and menu book located in the home revealed clients on a heart healthy diabetic diet should only receive one and one-half french toast sticks. Interview on 4/1/25 with the Hab Spec and facility nurse revealed client #1's diet order is current, and he should have been served one and one-half french toast sticks.	W 460		
W 489	DINING AREAS AND SERVICE CFR(s): 483.480(d)(5) The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all clients were fed in an upright position. This affected 1 of 6 audit clients (#5) observed eating breakfast. The finding is: Observations in the home on 4/1/25 revealed all clients began eating breakfast at 8:26am. Client #5 was observed laying in his bed in a supine position. Staff A was observed to feed client #5 his food and hold client #5's cup and straw for him to drink from. During the observation, client #5 remained in a supine position in bed. Review on 4/1/25 of client #5's person centered plan (PCP) dated 6/16/23 revealed no information regarding a recommendation that client #5 be fed in his bed or in a supine position. Interview on 4/1/25 with Staff B revealed they feed client #5 in his bed because once he has breakfast, he has a bowel movement and then	W 489		

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W 489	Continued From page 11 receives his morning care. Staff B stated it was easier to feed him in bed instead of transferring him back and forth from the bed to the dining table and back to the bed, as he is "heavy and dead on one side." Interview on 4/1/25 with the facility nurse revealed client #5 should never be fed in his bed nor in a supine position, as there is a risk of choking or aspiration.	W 489		