PRINTED: 01/10/2025 FORM APPROVED

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING		IPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G237	B. W1NG		0.4	/08/2025	
	PROVIDER OR SUPPLIER OOK GROUP HOME			STREET ADDRESS, CIIY, STATE, ZIP O 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	ODE	100/2025	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL	SHOULD DE	COMPLETION DATE	
	\$441.184(d)(1), §468 \$483.73(d)(1), §483 \$485.68(d)(1), §485 \$485.727(d)(1), §488 \$491.12(d)(1). *[For RNCHIs at §40 Hospitals at §482.15 at §484.102, REHs at garder §485.727, OP RHC/FQHCs at §497 (1) Training programe the following: (i) Initial training in empolicies and procedus staff, individuals programed arrangement, and vote expected roles. (ii) Provide emergency least every 2 years. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are significant must conduct training procedures. *[For Hospices at §47 hospice must do all of (i) Initial training in empolicies and procedure hospice employees, 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), §485.625(d)(1), 5.920(d)(1), §486.360(d)(1), 93.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" Os at §486.360, 1.12:] m. The [facility] must do all of mergency preparedness ares to all new and existing viding services under olunteers, consistent with their cy preparedness training at antation of all emergency g. If knowledge of emergency preparedness policies and ficantly updated, the [facility] on the updated policies and 18.113(d):] (1) Training. The	E 03	E037) QPwill provide in service train adhouse manager in Emergency Prepar rocedures. This will be monitored by fi mergency Preparedness Policies and ouse meeting. In the future, the QP will et aff are knowledgeable of the EmergrotocoL	edness Policiesan1 heQP reviewing the Procedures at each	1/23/2025	

(X6) DATE

Any deficiency state nt ending yUth 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 surveywhether or not a plan of correction is provided. Formursing 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 sited an approved plan of correction is requisite to continued days following thedate these document: are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 01/10/2025 FORM APPROVED 0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENIIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF DROVIDED OF	34G237	B. WING		01	/08/2025
NAME OF PROVIDER OR SUPPLIER PINEBROOK GROUP HOME			STREET ADDRESS, CNV, STATE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791	01	100/2025
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D DE	COMPLETION DATE
procedures. Qii) Provide emerge least every 2 years. Qv) Periodically rev emergency prepare employees (includin special emphasis pl procedures necessatothers. (v) Maintain docume preparedness trainin (vi) If the emergency procedures are sign must conduct trainin procedures. *[For PRTFs at §441 program. The PRTF Q) Initial training in expolicies and procedustaff, individuals provarrangement, and vocation expected roles. Qi) After initial trainin preparedness trainin Qii) Demonstrate station procedures. Qv) Maintain docume preparedness trainin (v) If the emergency procedures are significant conduct training procedures. *[For PACE at §460.8 organization must docume must docume preparedness.]	aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice g nonemployee staff), with aced on carrying out the ary to protect patients and entation of all emergency ng. I preparedness policies and ificantly updated, the hospice g on the updated policies and emergency preparedness ires to all new and existing viding se1Vices under solunteers, consistent with their g, provide emergency g every 2 years. If knowledge of emergency entation of all emergency g. I preparedness policies and ficantly updated, the PRTF g on the updated policies and 44(d):1 (1) The PACE	E 037			7/17/2025

PRINTED: 01/10/2025 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDERJSUPPLIER/CLIA IDENTIFICATION NUMBER:	(V2) MILL TIPLE CONSTRUCTION		(X3) DA1	(X3) DATE SURVEY COMPLETED	
		34G237	B, WING				
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CIIY, STATE, ZIP CODE	01	/08/2025	
	OOK GROUP HOME		30	01 ERKWOOD DRIVE ENDERSONVILLE, NC 28791			
(X4)10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D RE	COMPLETION DATE	
	starr, individuals programment, controlly volunteers, consisted Qi) Provide emerger least every 2 years. Qii) Demonstrate staprocedures, including what to do, where to case of an emerger Qv) Maintain docum (v) If the emergency procedures are sign must conduct training procedures. •[ForLTC Facilities a Program. The LTC facilities and procedures. •[ForLTC Facilities a Program. The LTC facilities and procedures. •[ForLTC Facilities a Program. The LTC facilities and procedures. •[ForCTC Facilities and procedus staff, individuals provarrangement, and volume preparedness training Qv) Provide emergen least annually. Qii) Maintain docume preparedness training Qv) Demonstrate staprocedures. •[ForCORFs at §485. CORF must do all of Q) Provide initial train preparedness policie and existing staff, individuals procedures.	ures to all new and existing oviding on-site seivices under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency of informing participants of o go, and whom to contact in necy. Incy. entation of all training. In preparedness policies and inficantly updated, the PACE go on the updated policies and acility must do all of the interest to all new and existing inding seivices under ollunteers, consistent with their cy preparedness training at entation of all emergency go. If knowledge of emergency for the following: ing in emergency in emergency in emergency services and procedures to all new inviduals providing seivices and volunteers, consistent all new inviduals providing seivices and volunteers. consistent	E 037			4/14/2025	

PRINTED: 01/10/2025 FORM APPROVED 0MB NO. 0938-0391

STATEMENT OF DE	FICIENCIES	(X1) PROVIDER/SUPPLIER/CUA			OMB NO	. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVID	ER OR SUPPLIER	34G237	8. WING_		01/	/08/2025
PINEBROOK G	ROUP HOME			STREET ADDRESS, CIIY, STATE, ZIP CODE 301 ERKWOOO DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX (I TAG R	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO IHE APPROP DEFICIENCY)	DRE	COMPLETION DATE
Qi) P least Qii) M Qv) D proce and a the C their f includ alarm equipp (v) If proce must c procec *[For (The C Q) Init policies report and w persor coope author individ and vo roles. Qi) Pro least e Qii) Ma Qv) De proced (v) If t proced	every 2 years. faintain docum permonstrate stadures. All new assigned specific ORF's emergerist workday. The instruction in systems and sment. The emergence dures are sign conduct training dures. CAHs at §485.6 CAH must do a dial training in eas and proceduring and extinguishere necessarinel, and gues ration with fire dities, to all new uals providing olunteers, considered emergence exercises and procedures are significant of the emergency lures are significant training on the emergency lures are significant training on training on the emergency lures are significant training of the emergency lures are significant training of the emergency lures are significant training of the emergency lures are significant training t	ncy preparedness training at	E 037			4/14/2025

PRINTED: 01/10/2025 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION		UMB NO. 0938-0391		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		(X3) DATE SURVEY COMPLETED	
	34G237	B. WING	B. WING		
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY, STATE, ZIP CODE	01/08/2025	
PINEBROOK GROUP HON			301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	D RE COMPLETION	
preparedness p and existing sta under arrangem with their expect documentation of demonstrate sta procedures. The emergency prep years. This STANDARI Based on recor failed to ensure the facility's Eme (EPP) at least bi Review of the fa was updated on revealed no evic training on the E Interview with th professional on the biennial training completed. W 125 PROTECTION C CFR(s): 483.420 The facility mus Therefore, the fa individual clients of the facility, and including the righ to due process. This STANDARD Based on observ	s §485.920(d):] (1) Training. The byide initial training in emergency oblicies and procedures to all new ff, individuals providing services ent, and volunteers, consistent ted roles, and maintain of the training. The CMHC must ff knowledge of emergency ereafter, the CMHC must provide aredness training at least every 2 is not met as evidenced by: d review and interview, the facility direct care staff were trained on engine preparedness Plan ennially. The finding is: cility's EPP on 1/8/25 revealed it 1/7/25. Continued review lence of initial or biennial staff PP.	i i c t s	(W 125) Hab. Specialist and QP volume of the support staff and house manager about the protection of clining the sand the importance of treating and treating the sand the importance of treating the sand the importance of treating the sand will explore furniture covering the same of	will in- se ient ng our t. The ngs also	

CENTERS FOR MEDICA	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			OMB N	D: 01/10/202 I APPROVE O. 0938-039
			the clinical team will complete environmental assessments future, QP will ensure people s are treated with dignity and re	monthly s. In the	
	(X1) PROVIDERISUPPUER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 34G237	A. BUILDING B. WING	3	COMF	
	IDENTIFICATION NUMBER: 34G237	A. BUILDING B. WING S)	COMF	PLETED

CENT	ERS FUR MEDICAR	RE & MEDICAID SERVICES			OMB	M APPROVE NO. 0938-039
W 248	During observation 1/8/25 client #3 w room couch with a visible under the cobservation reveation on another couch. Interviews with the professional (QIDI 1/7/25 and 1/8/25 the incontinence professional (QIDI 1/7/25 and 1/8/25 the incontinence pads dignity. PROGRAM IMPLE CFR(s): 483.440(d) As soon as the interview incontinence pads dignity. PROGRAM IMPLE CFR(s): 483.440(d) As soon as the interview incontinence pads dignity. This STANDARD is and frequency to sobjectives identified plan.	ty and respect regarding the use adding. The finding is: ans in the home on 1/7/25 and as observed sitting on a living an incontinence pad clearly client's body. Further aled an incontinence pad sitting in the living room. e qualified intellectual disability P) and Home Supervisor on revealed that the purpose of pads is to prevent damage to be performed that use of the violates the clients' right to		249		VO. 0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		34G237	B. WING		01	/08/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIIY, STATE, ZI		
PINEBRO	OOK GROUP HOME			301 ERKWOOD DRIVE HENDERSONVILLE, NC 2879	91	
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF K (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/10/2025

PRINTED: 01/10/2025 FORM APPROVED 0MB NO. 0938-0391

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 473 MEAL SERVICES CFR(s): 483.480(b)(2)(ii)

Food must be served at appropriate temperature.

W249

(W 249) Hab. Specialist will in-service support staff a n d house manager on active treatment to all people supported including those in wheelchairs. The Hah

Specialist will explore and incorporate meaningful ctivities through a consistent schedule for the people upported at home and once they return to the ocational center. This will be monitored by the linical terun completing two interaction assessments eekly for a period of one month, then on a routine asis. In the future, the QP will ensure that all people supported are involved in active treatment.

4/14/2025

W473

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

34G237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

301 ERKWOOD DRIVE

8W.ING

(X3) DATE SURVEY COMPLETED

01/08/2025

NAME OF PROVIDER OR SUPPLIER

PINEBROOK GROUP HOME

STREET ADDRESS, CIIY, STATE, ZIP CODE

HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE 4/14/2025

PRINTED: 01/10/2025 FORM APPROVED 0MB NO. 0938-0391

					OMB N	IO. 0938-039
W 47	failed to ensure a appropriate tempor finding is:	is not met as evidenced by: ations and inteiviews, the facilit Il foods were seived at an erature for 6 of 6 clients. The	W47 y			
	pizza boxes on the the home manage having pizza for dat 4:30 PM reveal in the oven, and to obseivations at 5:	n entering the group home on revealed two Papa John's e kitchen counter. Inteiview with er confirmed the clients are inner. Continued obseivations ed the pizza boxes to be placed for the oven to be off. Further 18 PM revealed all clients to be inner without it being reheated.		(W 473) Hab. Specialist will in-service sure that house manager about making sure that E.rved at appropriate temperatures. This monitored by the clinical team completing sments weekly for a period of one mon n a routine basis. In the future, QP will en I foods served to people supported are sppropriate temperatures.	t foods are s will be two meal th, then	
W 474	professional on 1	qualified intellectual disability /8/25 confirmed staff should pizza prior to seiving clients (2)(2)(iii)	W474			
	This STANDARD Based on obseiva inteiviews, the factorm consistent with	is not met as evidenced by: tions, record review, and ility failed to seive food in a th the developmental levels and f 5 of 6 clients (#1, #2, #3, #5	e	(W 474) Hab. Specialist will in-secupport staff and house managediet consistencies per resident developmental needs. This will be monitored by the clinical team ompleting two meal assessment eekly for a period of one month, n a consistent basis. In the future	er on De ots , then	4/14/2025
	Obseivations in the PM revealed the d	I to ensure the prescribed diet xample: e group home on 1/7/25 at 5:20 inner meal to be pizza and fruit bseivation revealed staff to		ill ensure that all residents are onsuming foods prepared with ppropriate consistencies according to their developmental needs.		
TATEMENT.						
AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	Marie William at a comme	LE CONSTRUCTION		SURVEY
		34G237	B. WING		01/0	08/2025
	PROVIDER OR SUPPLIER DOK GROUP HOME			STREET ADDRESS, CITY, STAIE, ZIP CODE 301 ERKWOOD DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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

PRINTED: 01/10/2025 FORM APPROVED 0MB NO. 0938-0391

W 474 Continued From page 8

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 staling 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

W474

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

34G237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING __

B. WING

(X3) DATE SURVEY COMPLETED

01/08/2025

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)

PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE
4/14/2025

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 to½" soft consistency for the client's safety.

D. The facility failed to follow client #5's diet as ordered. For example:

W474

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONS1RUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

34G237

B. WING

01/08/2025

NAME OF PROVIDER OR SUPPLIER

PINEBROOK GROUP HOME

STREET ADDRESS, CIIY, 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)

PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

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

Event ID: HPBY11

Facmty ID: 922389

If continuation sheet Page 11 of 13

PRINTED: 01/10/2025 FORM APPROVED 0MB NO. 0938-0391

W 474 Continued From page 10

Observations in the group home on 1/7/25 at 5:20 PM reveal.ed 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 1/8125 with the QIDP confirmed that client #S'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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STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTJFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

34G237

B. WING

01/08/2025

NAME OF PROVIDER OR SUPPLIER

PINEBROOK GROUP HOME

301 ERKWOOD DRIVE
HENDERSONVILLE, NC 28791
PROVIDER'S PLAN OF CO

STREET ADDRESS, CIIY, STATE, ZIP CODE

(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)

COMPLETION DATE

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.

Event ID: HPBY11

W474