STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G237	A. BUILDING _____ B. WING _____	R-C 05/16/2025

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
{W 000}	INITIAL COMMENTS A revisit was conducted on 5/16/25 for all previous deficiencies cited during the recertification survey on 1/8/25, a prior revisit on 3/9/25 and a complaint investigation on 4/1/25. All deficiencies were corrected for the recertification and the complaint investigations #NC00228224, #NC00228212, #NC00228216, #NC00228442, #NC00228541 and #NC00228594; However, new non-compliance was found.	{W 000}		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure enough trained staff were available on shift to meet the Person-Centered Plan (PCP) needs for 2 of 5 clients in the group home (#1 and #4). The findings are: A. The facility failed to ensure adequately trained staff were available during observations in the group home on 5/16/25 between 7:30 AM and 9:15 AM. Morning observations revealed 2 staff in the group home with client #1 eating breakfast in the dining room and not wearing his smart watch, which tracks his location, due to a history of elopement. Further observations revealed that after breakfast, client #1 asked staff A for permission to go outside and staff A gave	W 186		

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

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permission. Client #1 still did not have his smart watch on at that time. Continued observations revealed client #1 to reenter the home, at which time staff B prompted client #1 to put on his watch. Subsequent observations revealed client #1 to leave the home several more times without notifying staff and at times when staff were occupied with other duties and were not monitoring client #1's whereabouts.

Review of records on 5/16/25 revealed a PCP for client #1 dated 3/20/25 which states that client #1 requires a smart watch to monitor his location through GPS due to a history of elopement. The PCP further states that client #1 should always have line of sight supervision due to the elopement history.

Interview with staff B on 5/16/25 revealed they are temporary staff in this home and that they were told that client #1 can be out of the home alone if he is wearing his smart watch. Staff B specifically stated they were not told about line of sight supervision for client #1. Interview with the QIDP and Administrator on 5/16/25 revealed that, due to staff shortage for this group home, workers from other homes are being asked to provide care at Pinebrook on a rotating weekly basis. Due to having new staff each week, the QIDP goes to the group home every Monday morning to train the week's new staff on the specifics of this home. The QIDP was unable to provide details or documentation about the contents of the training being given to each new group of staff. Continued interview with the QIDP and the Administrator confirmed that client #1's PCP is current and that he should always have line of sight supervision which was observed not to occur during morning observations in the group

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W 186	Continued From page 2 home on 5/16/25. B. The facility failed to ensure adequately trained staff were available in the group home to tranfer client #4 appropriately. Morning observations in the group home on 5/16/25 at 9:03 AM revealed staff A and staff B to transfer client #4 from his bed to his wheelchair using a 2-person lift. Client #4 is quadriplegic and cannot assist with transfers. The staff struggled with the transfer and client #4 nearly slipped off the bed in the process. Further observation revealed a Hoyer lift outside of client #4's bedroom which was not in use at that time. Review of records on 5/16/25 revealed a PCP for client #4 dated 6/26/24 which states that, "client #4 is a Hoyer lift. 2-person lift for transfers if Hoyer is unavailable." Interview with staff A on 5/16/25 revealed that they are not trained on the use of the Hoyer lift. Interview with staff B on 5/16/25 revealed that they are trained on the use of the lift, but were told that client #4 is a 2-person lift for transfers. Staff B also confirmed that the lift is in working condition and was available at the time client #4 was transferred. Interview with the QIDP and the Administrator confirmed that client #4's PCP is current and that he should always be transferred using the Hoyer lift when it is available.	W 186		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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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, record review and interviews, the facility failed to ensure that 3 of 5 clients (#1, #3, #5) received a continuous active treatment program including services and interventions needed as identified in the Person-Centered Plan (PCP). The findings are:

A. Observations in the group home on 5/16/25 between 7:30 AM and 9:15 AM revealed client #1 eating breakfast in the dining room and not wearing his smart watch, which tracks his location, due to a history of elopement. Further observations revealed that after breakfast, client #1 asked staff A for permission to go outside and staff A gave permission. Client #1 still did not have his smart watch on at that time. Continued observations revealed client #1 to reenter the home, at which time staff B prompted client #1 to put on his watch. Subsequent observations revealed client #1 to leave the home several more times without notifying staff and at times when staff were occupied with other duties and at no time were staff monitoring client #1's whereabouts.

Review of records on 5/16/25 revealed a Person-Centered Plan (PCP) for client #1 dated 3/20/25 which states that client #1 requires a smart watch to monitor his location through GPS

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due to a history of elopement. The PCP further states that client #1 should always have line of sight supervision due to the elopement history.

Interview with the qualified intellectual disabilities professional (QIDP) and the Facility Administrator (FA) on 5/16/25 confirmed that client #1's PCP is current and that he should always wear his smart watch and have line of sight supervision.

B. Observations in the group home on 5/16/25 between 7:30 AM and 9:15 AM revealed client #3 to sit at the dining room table with an insulated cup for the entire observation. Client #3 was served breakfast at the table at 8:28 AM. Continued observation revealed client #3 did not get up from the table for the remainder of the observation which ended at 9:15 AM and during that time, no staff prompted client #3 to engage in any activity except eating breakfast.

Interview with the QIDP and the FA on 5/16/25 confirmed that staff should have prompted client #3 to engage in some type of active treatment rather than sitting at the dining room table for 75 minutes or more.

C. Observations in the group home on 5/16/25 between 8:19 AM and 8:54 AM revealed client #5 to eat breakfast in the dining room. Further observation revealed that between 8:28 AM and 8:54 AM client #5 requested coffee several times. Continued observation revealed staff A looked in the refrigerator, announced there was no creamer, and did not assist client #5 to prepare coffee nor make coffee for him.

Review of records on 5/16/25 revealed a Person-Centered Plan (PCP) for client #5 dated

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W 249	Continued From page 5 11/15/24 which lists, among client #5's goals, "Client #5 will make his morning coffee with gestural and verbal assistance 90% of the time." Interview with the QIDP and the FA on 5/16/25 confirmed that staff should have assisted client #5 to make his morning coffee.	W 249		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. 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 1 of 5 clients (#4). The finding is: Observations in the group home on 5/16/25 at 8:10 AM revealed staff A to prepare 4 individual dishes of oatmeal and to set them on the kitchen counter. Further observation at 9:10 AM revealed staff A to bring client #4 to the dining room table and to serve client #4 the oatmeal, which was dished out at 8:10 AM without re-heating the oatmeal. Interview with the qualified intellectual disabilities professional (QIDP) and the Facility Administrator on 5/16/25 confirmed that staff should have ensured that the food was held at an appropriate temperature and served to the client while it was warm.	W 473		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by:	W 481		

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W 481	Continued From page 6 Based on observations and interviews, the facility failed to ensure food substitutions and food actually served were documented. The finding is: Observations in the home on 5/16/25 between 7:30 AM and 9:15 AM revealed a menu book on the kitchen counter with pages lying loose outside of the binder. Further observation revealed a Menu Substitution Sheet in the same binder with the menu pages. The substitution sheet contained entries from 4/3/25 through 4/24/25 and no entries since. No further entries were made during the observation period. Interview with staff A on 5/16/25 revealed he was unaware which menu date to follow and, when asked if he had been trained on the use of the menu, stated, "They haven't told us much of anything and we're just winging it." Interview with the qualified intellectual disabilities professional (QIDP) and the Facility Administrator on 5/16/25 confirmed that staff should use the prescribed menus and should record any changes or substitutions to the menu.	W 481		
W 485	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must supervise and staff dining rooms adequately. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure meals in the home were adequately supervised to meet the needs of 1 of 5 clients (#5) in the home. The finding is: Observations in the group home on 5/16/25	W 485		

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between 8:19 AM to 8:54 AM, client #5 was seated at the dining room table eating breakfast. Further observations revealed staff to be busy around the home with various duties, but not supervising client #5 in the dining room. Continued observation revealed client #5 requested coffee several times during breakfast, but staff did not answer him and none was provided. At 8:54 AM, while staff were in another client's bedroom, client #5 took a travel mug from another resident and drank from it. Staff intervened after being notified by another client of what was happening. Subsequent observation at 9:00 AM revealed client #5 to drink from a bottle left out by staff and then to begin coughing. Again, staff were alerted by another client and responded to the situation.

Review of records on 5/16/25 revealed a Person-Centered Plan (PCP) for client #5 dated 11/15/24 which states that client #5's diet is ¼" chopped with thickened liquids. Client #5's PCP further states that staff must monitor him at all times while eating to avoid snatching of food and drinks from others.

Interview with the qualified intellectual disabilities professional (QIDP) and the Facility Administrator on 5/16/25 confirmed that staff should have monitored client #5 while he was eating to ensure he did not ingest un-thickened liquids.