PRINTED: 05/21/2025 FORM APPROVED DMB NO. 0938-0391

OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2)MULTIPLE CONSTRUCTION A BUILDING			10.0938-
	The real ballion I &			(X3) DATE SURVE COMPLETED	
DOCUMENT	34G237	B. WING_			R-C
PROVIDER OR SUPPLIER			STREET ADDRESS OF STREET	0	5/16/2025
OOK GROUP HOME				DE	
SUMMARY	STATEMENT OF DEFICIENCIES	1 15			
		PREFIX TAG	I GAUN CORRECTIVE ACTIONS	CHOULD DO	(X5) COMPLE DATE
A revisit was conducted previous deficiencies recertification survey 3/9/25 and a complaint deficiencies were contained the complaint in the work of t	cted on 5/16/25 for all socited during the con 1/8/25, a prior revisit on thinvestigation on 4/1/25. All rected for the recertification vestigations #NC00228224, 00228216, #NC00228442, NC00228594; However, new found.		the home through weekly in-serv supervision, weekly refresher tra plans, and weekly interaction assi 30-day period. QP will also comp service training on necessary eq devices, such as the smart watch This training will include relief state.	people within rice training on PCP assments for a lete weekly in- uipment and and Hoyer lift,	
Direct care staff are de conduty staff calculated period for each define. This STANDARD is no Based on observations interviews, the facility for cained staff were available person-Centered Plan	upervise clients in ndividual program plans.  efined as the present dover all shifts in a 24-hour dresidential living unit. It met as evidenced by:  s, record review and ailed to ensure enough able on shift to meet the (PCP) needs for 2 of 5.		RECEIVED	7	//15/202
The facility failed to					
arr were available dur roup home on 5/16/25 15 AM. Morning obse the group home with o the dining room and r atch, which tracks his I elopement. Further ob ter breakfast, client #1	ing observations in the between 7:30 AM and rvations revealed 2 staff dient#1 eating breakfast not wearing his smart ocation, due to a history servations revealed that asked staff A for	(,4,0	DHSR-MH Licensure Sect		
	PROVIDER OR SUPPLIER  SUMMARY: (EACH DEFICIEN REGULATORY OF  INITIAL COMMENTS  A revisit was conduct previous deficiencies recertification survey 3/9/25 and a complain deficiencies were contained the complaint int #NC00228212, #NC0 #NC00228541 and #N non-compliance was DIRECT CARE STAFI CFR(s): 483.430(d)(1.1  The facility must provious faff to manage and secondance with their int Direct care staff are defined to the complaint interviews, the facility failed to each defined staff were available during staff were available during staff were available during staff were available during the complaint in the group home on 5/16/25  The facility failed to each defined staff were available during staff were available during staff were available during staff were available during home on 5/16/25  The facility failed to each defined the during room and reach, which tracks his in the group home with contact the during room and reach, which tracks his in the preakfast, client #1	PROVIDER OR SUPPLIER  OK GROUP HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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, #NC00228594; However, new non-compliance was found.  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: lased on observations, record review and anterviews, the facility failed to ensure enough ained staff were available on shift to meet the erson-Centered Plan (PCP) needs for 2 of 5 lients in the group home (#1 and #4) The	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)  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 investigations #NC00228244, #NC00228212, #NC00228216, #NC00228442, #NC00228214, #NC00228214, #NC00228594; However, new non-compliance was found.  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 enduty staff calculated over all shifts in a 24-hour teriod for each defined residential living unit. This STANDARD is not met as evidenced by: lased on observations, record review and therviews, the facility failed to ensure enough alined staff were available on shift to meet the erson-Centered Plan (PCP) needs for 2 of 5 lients in the group home (#1 and #4). The indings are:  The facility failed to ensure adequately trained after were available during observations in the outphome on 5/16/25 between 7:30 AM and 15 AM. Morning observations revealed 2 staff the group home with client#1 eating breakfast the dining room and not wearing his smart tach, which tracks his location, due to a history elopement. Further observations revealed that er breakfast, client #1 asked staff A for mission to a cuttinity and the proper of the proper	A revisit was conducted on 5/16/25 for all previous deficiencies cited during the recertification survey on 18/25, a prior revisit on 39/28 and a complaint investigation on 4/1/25. All deficiencies were corrected for the recertification survey on 18/25, a prior revisit on 39/28 and a complaint investigation on 4/1/25. All deficiencies were corrected for the recertification and the complaint investigations #NC00228244, #NC00228541 and #NC00228545, However, new non-compliance was found.  DIRECT CARE STAFF  CFR(s): 483.430(d)(1-2)  The facility must provide sufficient direct care staff are defined as the present mediuty shaff calculated over all shifts in a 24-hour reiroid for each defined residential living unit. his STANDARD is not met as evidenced by: lased on observations, record review and therefieds in the group home (#1 and #4). The dility failed to ensure adequately trained aff were available during observations in the outpup home on 5/16/25 between 7:30 AM and 15 AM. Morning observations revealed 2 staff the group home with client#1 eating breakfast the dining room and not wearing his smart tach, which tracks his location, due to a history elopement. Further observations revealed that er breakfast, client #1 asked staff for missien to a work of the proup is a service which the representations are very all the propertions are very all the component of the proup home of the proup home with client#1 eating breakfast the dining room and not wearing his smart tach, which tracks his location, due to a history elopement. Further observations revealed that er breakfast, client #1 asked staff for missien as well as the propertion of the proup home of the proup	DENTIFICATION NUMBER  34G237  34G237  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 391 ERRWOOD DRIVE  BLIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECISED BY PILL REGULATORY OR LSC DENTIFY WIGHINFORMATION)  A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE 391 ERRWOOD DRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 391 ERRWOOD DRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER OR SUPPLIER  TAG  ID PROVIDER STATE, LIP CODE 391 ERRWOOD DRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD BRIVE  HENDERSONVILLE, NC 28791  ID PROVIDER STATE, LIP CODE 391 ERRWOOD  REAL CORRECTION  TAG  TAG  W 186) QP WIII INSURE dirECT INDRESS WING SUPPRISION, SERVED TO EXCEPT A TO

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

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	/Y2\MIII TIDI E		OMB N	0.0938-0
- AND OF CORRECTION	CORRECTION CATTON NUMBER: (X2)MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED	
VALUE OF C	34G237	B. WING			R-C
NAME OF PROVIDER OR SUPPLIER			DETAR	0.5	5/16/2025
PINEBROOK GROUP HOME		30	REET ADDRESS, CITY, STATE, ZIP CO 1 ERKWOOD DRIVE NDERSONVILLE, NC 28791	DE	
	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	CHOIL DE	(X5) COMPLETI DATE
revealed client #1 to time staff B prompter watch. Subsequent of #1 to leave the home notifying staff and at occupied with other of monitoring client #1's  Review of records on a client #1 dated 3/20/28 requires a smart watch through GPS due to a PCP further states that have line of sight supelopement history.  Interview with staff B of are temporary staff in twere told that client #1 alone if he is wearing if specifically stated they sight supervision for client and Administrator due to staff shortage for workers from other homoprovide care at Pinebrobasis. Due to having need to provide details or documents of the training group of staff. Continue and the Administrator of PCP is current and that line of sight supervision.	1 still did not have his smart 2. Continued observations reenter the home, at which d client #1 to put on his observations revealed client several more times without times when staff were luties and were not s whereabouts.  5/16/25 revealed a PCP for 5 which states that client #1 h to monitor his location history of elopement. The t client #1 should always ervision due to the  on 5/16/25 revealed they this home and that they can be out of the home his smart watch. Staff B were not told about line of ient #1. Interview with the or on 5/16/25 revealed that, or this group home, mes are being asked to book on a rotating weekly ew staff each week, the o home every Monday ek's new staff on the The QIDP was unable to mentation about the being given to each new d interview with the QIDP onfirmed that client #1's	W 186	DEFICIENCY	7)	/15/2025

ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2)MIII TIDI	ECONOTE	OMB N	0.0938-0
- Corre	S. SORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ECONSTRUCTION	(X3) DAT	E SURVEY IPLETED
IAME OF		34G237	B. WING		F	R-C
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS	05	/16/2025
INEBRO	OOK GROUP HOME			TREET ADDRESS, CITY, STATE, ZIP COL	DE	
				01 ERKWOOD DRIVE		
(X4) ID PREFIX	SUMMARYS	STATEMENT OF DEFICIENCIES	T	ENDERSONVILLE, NC 28791		
TAG	( LACITUE TILLEN	CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVEACTIONS CROSS-REFERENCED TO THE AF DEFICIENCY)	LIOLII D DE	(X5) COMPLET DATE
1	home on 5/16/25.  B. The facility failed to staff were available in client #4 appropriate! the group home on 5/ staff A and staff B to the bed to his wheelchair #4 is quadriplegic and transfers. The staff strand client #4 nearly sliprocess. Further obseroutside of client #4's buse at that time.  Review of records on 5-client #4 dated 6/26/24 #4 is a Hoyer lift. 2-per	The facility failed to ensure adequately trained aff were available in the group home to tranfer ent #4 appropriately. Morning observations in a group home on 5/16/25 at 9:03 AM revealed ff A and staff B to transfer client #4 from his dot to his wheelchair using a 2-person lift. Client is quadriplegic and cannot assist with the sfers. The staff struggled with the transfer dollent #4 nearly slipped off the bed in the cess. Further observation revealed a Hoyer lift side of client #4's bedroom which was not in		W 249) QP will ensure direct I supervision is given to necessary he home through weekly in-serv supervision, weekly refresher tra lans, and weekly interaction asset 0 day period. QP will also compleservice training on necessary equevices, such as the smart watch his training will include relief staff so be monitored during the wee assessments.	people within ice training on ining on PCP assments for a lete weekly inuipment and and Hoyer lift.	
li tr ir tr tc S	ney are not trained on nterview with staff B or ney are trained on the old that client #4 is a 2- staff B also confirmed t	n 5/16/25 revealed that the use of the Hoyer lift. n 5/16/25 revealed that use of the lift, but were person lift for transfers. that the lift is in working able at the time client #4			7/	15/2025
249 PI CI	terview with the QIDP onfirmed that client #4' e should always be trat when it is available. ROGRAM IMPLEMENT FR(s): 483.440(d)(1) as soon as the interdisci rmulated a client's indi	's PCP is current and that nsferred using the Hoyer  FATION  Plinary team has	W 249			

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	JA (X2)MULTIPLECONSTRUCTION		OMB NO. 0938-0	
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DA	TE SURVEY MPLETED
	34G237	B. WING			R-C
IAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	0	5/16/2025
INEBROOK GROUP HOME		30	01 ERKWOOD DRIVE ENDERSONVILLE, NC 28791	DDE	
CAUT DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVEACTION CROSS-REFERENCED TO THE A DEFICIENCY)	CHOILD DE	(X5) COMPLETION DATE
interventions and se and frequency to sup objectives identified plan.  This STANDARD is repaired by the facility clients (#1, #3, #5) recorded for the facility clients (#1, #3, #	reive a continuous active consisting of needed rvices in sufficient number uport the achievement of the in the individual program record review and failed to ensure that 3 of 5 ceived a continuous active cluding services and as identified in the in (PCP). The findings are:  If group home on 5/16/25 g:15 AM revealed client #1 adining room and not ch, which tracks his cry of elopement. Further that after breakfast, client rmission to go outside and in. Client #1 still did not on at that time. Continued client #1 to reenter the left B prompted client #1 to equent observations ave the home several ifying staff and at times ed with other duties and at itoring client #1's	W 249	DEFICIENCY)		/15/2025

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CV2) MIII TIOL		OMB N	O. 0938-0
WD PEAN	IDENTIFICATION NI MADED.		A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G237	B. WING		1 1	R-C
NAME OF	PROVIDER OR SUPPLIER					5/16/2025
PINERRO	OK GROUP HOME			REET ADDRESS, CITY, STATE, ZIP COL	DE	3/10/2023
	OK GROUP HOME		2	1 ERKWOOD DRIVE		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	HE	NDERSONVILLE, NC 28791		
PREFIX	I CAUT DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVEACTIONS CROSS-REFERENCED TO THE AF DEFICIENCY)	HOLE D. D.	(X5) COMPLET DATE
Ir cc ## ram m C. be to ob. 8:4	due to a history of elostates that client#1 sight supervision due  Interview with the qual professional (QIDP) at (FA) on 5/16/25 confincurrent and that he showatch and have line of the between 7:30 AM and to sit at the dining roor cup for the entire observed breakfast at the Continued observation which end that time, no staff proming activity except eating the room of the ending that the continued observation which end that time, no staff proming activity except eating the room of the ending that the continued observation in the great breakfast in the dispervation revealed the servation revealed the continued observation revealed the con	opement. The PCP further should always have line of to the elopement history.  Illified intellectual disabilities and the Facility Administrator remed that client #1's PCP is ould always wear his smart of sight supervision.  If group home on 5/16/25  19:15 AM revealed client #3 metable with an insulated ervation. Client #3 was atable at 8:28 AM.  In revealed client #3 did not or the remainder of the led at 9:15 AM and during pted client #3 to engage in ang breakfast.  If and the FA on 5/16/25 and the	W 249	DEFICIENCY		15/2025
Re	ffee nor make coffee eview of records on 5/ rson-Centered Plan (F					

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2)AH II TIS	O E COMPANIE TO SE	OMB N	O. 0938-03
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
NAMEOF	DDOMBER	34G237	B. WING			R-C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 301 ERKWOOD DRIVE	0	5/16/2025
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		HENDERSONVILLE, NC 28791		
PREFIX TAG	I IEACH DEFICIEN	CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVEACTIONSI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOI II D DE	(X5) COMPLETION DATE
	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.  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		W 473	W 473) QP will ensure meal plant followed correctly through the week review (containing meal notes) of period. Compliance with the plan with through biweekly mealtime assocompleted by both QP and house w 481) QP will ensure meal plant documented correctly through mealtime and substitution in-services, for a 30-day period. Compliation will be ensured through biweek assessments completed by both Q manager.	ekly PCP chart ver a 30-day ill be ensured dessments de manager.  Is are being a weekly rice training ance with the kly mealtime P and house	
W 481 M C	counter. Further observed and to serve client #4 to	to set them on the kitchen vation at 9:10 AM revealed 4 to the dining room table the oatmeal, which was without re-heating the	W 481		7.	/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	CYZIMIII	TIPLECONSTRUCTION	OMB N	O. 0938-039
AND FLA	IN OF CORRECTION	IDENTIFICATION NUMBER:		ING	(X3)DA COI	TE SURVEY MPLETED
NAME		34G237	B. WING			R-C
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	05	5/16/2025
PINEB	ROOK GROUP HOME			301 ERKWOOD DRIVE	ODE	
(VA) II	2000			HENDERSONVILLE, NC 28791		
(X4) II PREFI	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DDDEGTION	
TAG	REGULATORYO	RLSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	NSHOULD BE EAPPROPRIATE	COMPLETION DATE
W 48	Ochunded From pag	ge 6	W4	81 W 485) QP will ensure meal	plane are but	
	Based on observation	ons and interviews, the facility	"	politived correctly inrough the	HERLY DOD	
	raneu to ensure 1000	Substitutions and food		I TO VICTO LUMINIMO MAN NATA	1 000 - 00 1	1
	actually served were	documented. The finding is:		period. Compliance with the pla through biweekly mealtime	n will be ensured	
	Observations in the h	nome on 5/16/25 between		completed by both QP and he	assessments ouse manager	
	7:30 AM and 9:15 AM	A revealed a menu book on		-	aco manager.	
	ine kitchen counterw	ith pages lying loose outside				
	of the billider, runner	Observation revealed a				
	wenu Substitution Sh	eet in the same hinder with				
	me menu pages. The	Substitution sheet				
	and no entries since	n 4/3/25 through 4/24/25 No further entries were				
	made during the obse	ervation period.				
	Interview with staff A c	on 5/16/25 revealed he was				
	unaware which menu	date to follow and, when				
	menu stated "Though	trained on the use of the aven't told us much of				
	anything and we're jus	st winging it."				
	Interview with the quali	fied intellectual disabilities			7/	/15/2025
	professional (QIDP) an	d the Facility Administrator				
	prescribed menus and	that staff should use the				
1	changes or substitution	should record any				
W 485	DINING AREAS AND S	FRVICE				
	CFR(s): 483.480(d)(4)	LIVIOL	W 485			
	The facility must super	vise and staff dining rooms				
	adequately.	1				
1	This STANDARD is no	t met as evidenced by:				
	Based on observations interviews, the facility for	, record review and ailed to ensure meals in				
	the home were adequa	tely supervised to meet				
	the needs of 1 of 5 clien finding is:	ts (#5) in the home. The				
	Observations in the gro	up home on 5/16/25				

AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE A. BUILDING	CONSTRUCTION	(X3)	NO. 0938-03 DATE SURVEY COMPLETED
NAMEOF	DROWDED CO	34G237	B. WING			R-C
	PROVIDER OR SUPPLIER  POK GROUP HOME		301	REET ADDRESS, CITY, STATE, ZI I ERKWOOD DRIVE NDERSONVILLE, NC 28791	PCODE	05/16/2025
(X4) ID PREFIX TAG	(CACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO 1 DEFICIENCE	TIONSHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
I F	between 8:19 AM to seated at the dining Further observation around the home w supervising client #3. Continued observation requested coffee set but staff did not ansiprovided. At 8:54 AM client's bedroom, clien	o 8:54 AM, client #5 was room table eating breakfast. It is revealed staff to be busy lith various duties, but not in the dining room. It is in the dining room. It is in the dining room. It is in the dining breakfast, wer him and none was in while staff were in another ent #5 took a travel mug from it in the dining from it. Staff in the dining from it. Staff in the dining from a bottle in the from a bottle in the dining from a bottle in the dining from a bottle in the dining from a bottle in the from	W 485			7/15/2025