STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G237	A. BUILDING _____ B. WING _____	02/18/2026

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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039	(E039) The Executive Director will in-service the QP on the protocol for conducting full scale-community, facility-based training, mocked drills and tabletop exercises. The QP will coordinate with the Home Manager to perform a mock and/or natural drill with support staff at the home which includes the community. A live event was completed on 2/1/2026 and referenced in the Emergency Preparedness Plan. In the future, the QP will ensure proper protocols are followed for full scale-community, facility-based training, mocked drills and tabletop exercises and documented on the action hours report.	4/19/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dr. K Pryor-Goins	Director of Operations	3/13/26

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.

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E 039	Continued From page 1 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's) response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's) emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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E 039	Continued From page 2 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 5 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 6 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 7 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360) {d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 8 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct a second full scale-community or facility based training or mock drill, or a tabletop exercise for testing of the facility's emergency preparedness plan (EPP). The finding is: Review on 2/17/26 of the facility's EPP revealed no evidence of a second full scale-community or facility-based training or mock drill, or a tabletop exercise.	E 039		

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E 039	Continued From page 9 Interview on 2/18/26 with the program manager (PM) confirmed the facility has not conducted a second full scale-community or facility-based training or mock drill, or a tabletop exercise.	E 039		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interview, the facility failed to provide opportunities for choice and self- management during mealtime for 2 of 4 audited clients (#1 and #2). The finding is: Observations in the group home on 2/18/26 at 8:35 AM revealed client #2 to sit at the dining room table to prepare for the breakfast meal which consisted of pancakes with sugar free syrup and turkey sausage. Further observations at 8:45 AM revealed client #1 to participate in the breakfast meal by sitting at the dining room table. Continued observations revealed staff C to prepare plates in the kitchen and serve them to client #1 and client #2. At no time during the observations were clients #1 and #2 allowed the opportunity to serve the breakfast meal. Review of records on 2/18/26 for client #1 revealed a person-centered plan (PCP) dated 9/17/25. Review of the PCP revealed adaptive behavior inventory dated 10/14/25 that states the client can serve self from bowl/platter and pass bowl/platter with total independence. Review of records on 2/18/26 for client #2	W247	(W247) The Habilitation Specialist will re-train Support Staff on ensuring people supported have the opportunity for client choice and self-management which includes participation in meal prep and family style dining. The Interdisciplinary Team will have a Mini Team to address Client#6 on how to best support him during family-style dining. The recommendations will be added to his PCP and shared with staff. This will be monitored by the clinical team completing 2 mealtime assessments per week for a period of one month and then on a routine basis. In the future, the QP will ensure people supported have the opportunity for client choice and self-management.	4/19/2026

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W 247	Continued From page 10 revealed a PCP dated 3/20/25. Review of the PCP revealed adaptive behavior inventory dated 10/13/25 that states the client can serve self from bowl/platter and pass bowl/platter with total independence and self-initiation of the task. Interview on 2/18/26 with the qualified intellectual disabilities professional (QIDP) and program manager (PM) revealed that staff should have allowed client #1 and client #2 to serve their meals. Further interview with the QIDP and PM revealed that clients should be able to participate when able to do so.	W247	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, 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 reviews, and interview, the facility failed to assure a continuous active treatment program identified as an individual need that was not implemented for 3 of 4 audited clients (#2, #5, and #6) relative to prescribed adaptive equipment. The findings are: A. The facility failed to provide prescribed adaptive equipment to client #2. For example:	W249	(W249) The Habilitation Specialist will re-train support staff on people supported adaptive equipment and eating guidelines in the home for clients # 2, 5, and 6. This will be monitored by the clinical team completing two interaction assessments per week and two mealtime assessments per week for a period of one month and then on a routine basis. In the future, the QP will ensure clients 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. 4/19/2026

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Observations in the group home from 2/17-2/18/26 revealed client #2 to watch television, participate in the dinner meal, breakfast meal, and medication administration. Further observations revealed that at no time did staff provide client #2 with prescribed Comfy Splint (left hand) or soft foam roll as an alternative to splint wear.

Review of records for client #2 on 2/18/26 revealed a person-centered plan (PCP) dated 10/9/25. Further review of the PCP revealed that the client is prescribed a Comfy Splint to the left hand for stability to be worn daily or a soft foam roll as an alternative to splint wear worn daily. The therapist recommends that the client continues to use a roll washcloth or foam roll in his hand as an alternative to splint wear.

Interview on 2/18/26 with the qualified intellectual disabilities professional (QIDP) and the program manager (PM) confirmed that client #2's PCP was current. Further interview with the QIDP and PM confirmed that staff should be providing the client with prescribed adaptive equipment which includes Comfy Splint or alternative soft foam roll or rolled wash cloth.

B. The facility failed to provide prescribed adaptive equipment for client #5. For example:

Observations in the group home on /18/26 at 8:35 AM revealed client #5 to sit at the dining table to prepare for the breakfast meal. Further observations revealed the client to eat his meals with a regular cup, plate, and fork. Continued observations revealed client #5 to eat his meal at a fast rate and to stack his food in large amounts on the fork. Subsequently observation at 8:37 **AM**

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W 249	Continued From page 12	W249		

revealed the client to have consumed the entire breakfast meal in 2 minutes. At no time during observations did staff prompt the client to slow down nor provide client #5 with prescribed small spoon and small fork.

Review of records for client #5 on 2/18/26 revealed a PCP dated 15/20/25. Further review of the PCP revealed the client to be prescribed a heart healthy, whole consistency diet 1" consistency and slow rate of eating. A nutritional assessment dated 1/30/26 recommends continued nutritional plan that includes prescribed adaptive equipment of a small spoon and fork.

Interview on 2/18/26 with the QIDP and PM confirmed that client's PCP was current. Further interview with the QIDP and PM confirmed that staff should provide adaptive equipment as prescribed and monitor client #5's rate of eating and provide prompts to slow down.

C. The facility failed to provide prescribed adaptive equipment for client #6. For example:

Observations in the group home on 2/17-2/18/26 revealed client #6 to consume the entire dinner meal and breakfast meal. Further observations revealed the client to eat his meals with a scoop plate, built fork, and built spoon. Continued observations revealed client #6 to eat his meal and cough during the meal. At no time during observations did staff sit with the client and provide the client with prescribed high-side divided dish, small fork and small spoon.

Review of records for client #6 on 2/18/26 revealed a PCP dated 11/15/25. Further review of the PCP revealed a nutritional assessment (NA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G237	A. BUILDING _____ B. WING _____	02/18/2026

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 249	Continued From page 13 dated 11/30/25 for the client to be prescribed with the following adaptive equipment: high-sided divided dish, non-skid mat, small fork/spoon. The staff are to sit with the client during meals providing verbal prompts and hand-over-hand assist as needed to prevent rapid eating and to encourage small bites. Interview on 2/18/26 with the QIDP and PM confirmed that client #G's PCP was current. Further interview with the QIDP and PM confirmed that staff should sit with the client and provide prescribed adaptive equipment.	W249		
W 340	**NURSING** SERVICES CFR(s): 483.460(c)(5)(i) 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 interview, the facility failed to ensure staff were sufficiently trained to properly utilize latex gloves. The finding is: Observations at the Vocational Center on 2/17/26 at 12:45 PM revealed staff to assist clients with the lunch meal. Further observations 12:53 PM revealed staff A to wear latex gloves to assist two clients with preparing lunch items in the microwave. Continued observations revealed the staff spoon fed one client and hand fed another client sandwich pieces. Subsequent observations revealed the staff wiped one client's face with a wet wipe and continued to hand feed another client sandwich pieces. At no time was staff	W340		

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W 340	Continued From page 14 observed to change gloves or wash/sanitize hands while feeding the two clients their lunch. Observations in the group home on 2/17/26 at 3:50 PM revealed staff B to assist client #2 with putting on latex gloves to assist in the kitchen. Further observation revealed staff B to put on a pair of latex gloves and prompt the client to assist with stirring meat in a bowl on the counter. Continued observations revealed staff B to unlock fridge to remove a milk carton and to wash a spoon in the sink while wearing the same latex gloves. Subsequent observations revealed staff B to prompt client #2 to add noodles to the meat bowl and stir in cheese, throw packages in trash, put glasses containing juice on the table, and stir pots. The client was not prompted to change gloves while assisting in the kitchen or washing/sanitizing hands and nor did staff utilize latex gloves properly. Interview on 2/18/26 with the facility nurse revealed that staff and clients should have changed latex gloves and washed hands to prevent cross contamination.	W340	(W340) Nursing will re-train support staff on proper utilization of latex gloves. This will be monitored by the clinical team. Nursing will provide one-on-one training with staff Hand Washing Education. In the future, the QP will ensure support staff utilize gloves appropriately to prevent cross contamination. (	4/19/2026
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 4 audited clients (#5) was administered medication in compliance with the physician orders. The finding is:	W368	W368) Nursing will re-train support staff on proper medication administration protocol which includes notifying nursing immediately if a medication is not present. In addition, nursing will follow-up with the homes when medications are sent to local pharmacy for pick-up. In the future, Nursing will ensure assure that all medication are administered in compliance with the physician's	4/19/2026

	orders. Nursing will ensure all medications are to be administered as transcribed by Physician Order in the Individual's MAR on a daily basis.	

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W 368	Continued From page 15 Observation in the group home on 2/18/26 at 7:27 AM revealed client #5 to exit the bedroom with staff assist. Further observations at 7:36 AM revealed the client entered the medication administration room with staff assisting as to prepare for medication administration. Continued observations revealed client #5 to participate in the morning medication administration and to be given medications in applesauce. Subsequent observation at 7:44 AM revealed the home manager (HM) to notify the facility nurse that client #5's Acidophilus CAP was not available in the home. Review of records for client #5 on 2/18/26 revealed physician's orders (P.O.) dated 2/18/26. Review of the 2/18/26 P.O.'s revealed that client #5 is prescribed Acidophilus CAP tab 25 to be administered at 8:00 AM and 8:00 PM daily for 14 days. Interview with the facility nurse on 2/18/26 confirmed the 2/18/26 P.O.'s for client #5 to be current. Further interview with the facility nurse revealed that client #5 has missed two doses of Acidophilus CAP prescribed to treat a rash on client #5's buttocks. Continued interview revealed that the facility nurse informed the client's primary care physician (PCP) of missed doses.	W368	
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to first, second and third shift. The finding	W440	W440) The QP will re-train support staff and home manager on the proper protocol for completing fire drills. The QP will coordinate a facility fire drill schedule (if there is not already a schedule) that should be followed monthly. In addition, the QP will review the fire drill every month once completed. In the future, the QP will ensure quarterly fire drills are conducted with each shift of personnel relative to first, second and third shift and documented accordingly. 4/19/2026

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W 440	Continued From page 16 is: Review of the facility fire drill reports from 2/25 through 1/26 revealed missing fire drills for 2/25, 3/25, 4/25, 9/25, and 11/25. There was a drill conducted on 8/24/25; however, no time or shift noted on the report. Further review of the fire drill reports revealed first shift drills conducted on 10/1/25 and 1/5/26; second shift drills conducted on 5/13/25 and 7/13/25; and third shift drills completed on 6/15/25 and 12/4/25. There was no additional documentation available regarding the missing fire drills during the review year. Interview with the qualified intellectual disabilities professional (QIDP) on 2/18/26 confirmed fire drills should have been conducted quarterly for each shift. Continued interview QIDP confirmed that all requested documentation for fire drills conducted 2/25 through 1/26 were provided to the surveyor.	W440		