		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:				
		MHL092-676	B. WING			R 26/2018
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RALPH D	RIVE HOME		PH DRIVE			
		CARY, N	C 27513			1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An Annual and Follow Up Survey was completed 04/26/18. A deficiency was cited.					
	This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
V 290	27G .5602 Supervised Living - Staff		V 290			
	 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with 					
	developmental disa one staff present fo	r adolescents with bilities shall be served with r every one to three clients aff present for every four or				

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-676	B. WING			R 04/26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RALPHI	DRIVE HOME		PH DRIVE C 27513			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From page 1 more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.		V 290			
	interview, the facility ratios above the mi	on, record review and y failed to maintain staff-client nimum numbers to enable ndividualized needs for four of				
	clients revealed: Client #1- diagnose Retardation, Visual Client #2- diagnose Microcephaly, Bell's Syndrome Client #4- diagnose	B of the facility's records for the s included Profound Mental ly and Hearing Impaired is included Mental Retardation Palsy and Damdy-Walker is included Severe Mental Palate, Febrile Seizures and				
	She had been rece	04/24/18, staff #2 reported: ntly hired the facility for two days.				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-676		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED R 04/26/2018	
		MHL092-676					
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	•		
			PH DRIVE				
RALPH	DRIVE HOME	CARY, N					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
V 290	Continued From pa	ge 2	V 290				
	During interview on 04/24/18, staff #1 reported:						
		2nd shift between 3-11P					
		She worked at the facility for the past few months					
	alone.						
	She was informed the facility should have two						
	staff on the second shift.						
	Clients #1-#3 required physical assistance with bathing and activities of daily living, client #4						
	could do things on her own with monitoring.						
	J	5					
	During interviews between 04/24/18 and						
	04/25/18, the Qualified Professional reported:						
	She completed the staff schedule for this home.						
	Staff #3 worked the first shift. However, staff #3 was on vacation the week of April 23, 2018. While						
	staff #3 was on vacation, she provided						
	transportation for clients at this house during the						
	day to various day programs. All clients except						
	client #1 went to a day program on April 24, 2018.						
	Client #1 did not attend a day program today so						
	her.	ouse provided monitoring for					
		dget included two staff on					
		e staff on each of the other					
		8, the clients were home					
	during the day, now	, most were enrolled in day					
	programs.						
		group home did not have					
	adequate staffing to accommodate the three						
	shifts inclusive of as relief and paraprofessional staff in cases of call ins, vacations and						
	emergencies.						
	5	en in the process of hiring					
	staff to meet the ne	eds of the clients in the home.					
		stain staff either during					
		or after a few weeks of work.					
		teran staff that had resigned					
		er home which impacted the coverage at other homes.					

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