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PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 5/8/18 of the facility's emergency preparedness (EP) manual (2017) did not include any information regarding alternate means of communication. During an interview on 5/8/18, the qualified intellectual disabilities professional (QIDP) stated an alternate communication plan "has not been put in place."	E 032		

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

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W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based onobservations, record reviews and interviews, the facility failed to ensure 4 of 6 audit clients (#1, #3, #4, #6) had the right to be addressed by their legal name and have a consent obtained by their legal guardians. The findings are: 1. Consents were not signed by the legal guardians for clients #1, #3 and #6. a. Review on 5/9/18 of client #1's record revealed a behavior support plan (BSP) dated 12/26/17. Further review revealed client #1's behavior medications are: Tegretol, Depakote, Abilify and Ativan. Additional review of client #1's record revealed he does not have a current behavior consent signed by his legal guardians. b. Review 5/9/18 of client #3's record revealed a BSP dated 9/2/17. Further review revealed client #3's behavior medications are: Prozac and Ativan. Additional review of client #3's record revealed he does not have a current behavior consent signed by his legal guardians. c. Review 5/9/18 of client #6's record revealed a BSP dated 12/30/17. Further review revealed client #6's behavior medications are: Abilify and Onfi. Additional review of client #6's record revealed her BSP consent expired on 4/4/17.	W 125		

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W 125	Continued From page 2 During an interview on 5/9/18, the qualified intellectual disabilities professional (QIDP) confirmed clients #1 and #3 records did not have a BSP consent for their medications signed by their legal guardians. The QIDP also confirmed client #6's consent for her behavior medications had expired. 2. Client #4 was not referred to by his legal name. During morning observations at the day program on 5/8/18, staff were heard calling client #4 "Wee-Wee." During afternoon observations in the home on 5/8/18, staff were heard calling client #4 "Wee-Wee." Review on 5/9/18 of client #4's record did not reveal any nicknames in which client #4 prefers to be called. Further review revealed client #4 should be called by his given name. During an interview on 5/9/18, staff revealed how a former client would call client #4 "Wee-Wee" and then staff began to use the nickname too. During an interview on 5/9/18, the QIDP confirmed client #4 does not have any nicknames and should be called by his first name.	W 125		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively,	W 189		

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W 189	Continued From page 3	W 189		

efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure all staff were sufficiently trained to perform their duties efficiently. This potentially could affect 2 of 6 audit clients (#4, #5). The findings are:

1. Staff did not ensure clients #4 and #5 wheelchair seatbelts were fastened.

During afternoon observations on 5/8/18 in the home from approximatley 4:09pm until 4:25pm, client #4 was seating in his wheelchair without the seatbelt being fastened. Further observations revealed client #4 being propelled by staff around in the living room area. At no time did staff fasten client #4's seatbelt.

During afternoon observations on 5/8/18 in the home from approximately 4:09pm until 4:50pm, client #5 was seating in his wheelchair without the seatbelt being fastened. Further observations revealed client #5 self-propelling the wheelchair with his feet, while sitting in the living room area. At no time did staff fasten client #5's seatbelt.

During an interview on 5/9/18, the qualified intellectual disabilities professional (QIDP) stated clients #4 and #5 wheelchair seatbelts should be fastened "at all times, while they are in their wheelchairs."

2. Staff did not ensure clients #4 and #5 wheelchairs were locked during transfers.

During afternoon observations in the home on

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W 189	Continued From page 4 5/8/18, clients #4 and #5 were being transferred from their wheelchairs to the dining room chairs. During the transfers both client #4's and #5's wheelchairs breaks were not locked. Further observations revealed client #4's and #5's wheelchairs rolled back while they were being transferred. At no time did staff lock either clients #4 or #5 wheelchair locks. During an interview on 5/9/18, the qualified intellectual disabilities professional (QIDP) stated clients #4 and #5 wheelchair breaks should be locked at all times during transfers.	W 189		
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain in a timely manner a auditory assessment for 1 newly admitted client (#3). The finding is: The facility failed to obtain a auditory assessment for client #3 in a timely manner. Review on 5/9/18 of client #3's individual program plan (IPP) dated 9/13/17 revealed he was admitted to the facility on 8/14/17. Further review of client #2's record revealed there is no record of his initial auditory assessment. During an interview on 5/9/18, the qualified intellectual disabilities professional (QIDP) stated she was unaware client #3's initial auditory	W 221		

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W 221	Continued From page 5 assessment did not occurr within 30 days of admission.	W 221		
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 interviews, the facility failed to ensure 5 of 6 audit clients (#2, #3, #4, #5, #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of dining, adaptive dining equipment, medication administration, eyeglass wear and diet. The findings are: 1. Client #2 was not prmpted to utilize a knife during meals. During dinner observations in the home on 5/8/18, client #2's meal consisted of ham, collard greens, yams, corn bread and chocolate brownies. Client #2 was observed picking up a 2 inch piece of ham, with his fingers and biting it. Further observations revealed client #2 consumed 3 additional pieces of ham in the same manner. Additional observations revealed client	W 249		

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#2 did not have a knife at his place setting. At no time was client #2 offered a knife while eating.

During breakfast observations in the home on 5/9/18, client #2's meal consisted of pancakes and eggs. Client #2 was observed picking up the round sized pancakes with his fingers, folding it in half and biting it. Further observations revealed client #2 consumed 4 pancakes in this manner. Additional observations revealed client #2 did not have a knife at his place setting. At no time was client #2 offered a knife while eating.

During an interview on 5/9/18, staff stated client #2 does not use a knife. Further interview revealed even if client #2 is offered a knife he will not utilize it.

Review on 5/9/18 of client #2's adaptive behavior inventory (ABI) dated 3/1/11 stated he uses a knife independently.

During an interview on 5/9/18, the qualified intellectual disabilities professional (QIDP) confirmed client #2 should have been prompted to use a knife during his meals.

2. Client #4 did not utilize his adaptive dining equipment.

During lunch observations at the day program on 5/8/18, client #4 consumed his lunch using a built-up handle spoon.

During dinner observations in the home on 5/8/18, client #4 consumed his dinner with a long handle, coated spoon.

During breakfast observations in the home on

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W 249	Continued From page 7 5/9/18, client #4 consumed his breakfast with a long handle, coated spoon. Review on 5/9/18 of client #4's nursing evaluation dated 3/1/18 stated, "uses maroon spoon." During an interview on 5/9/18, the QIDP and life skills specialist were both unaware client #4 utilized a maroon spoon. 3. Client #5 was afforded the ability to fully particiapte in medication administration. During afternoon medication administration in the home on 5/8/18, the medication technician held up a disposable paper cup to client #5's mouth while he took sips of water. At no time was client #5 offered his adaptive cup. During mealtime observations at the day program and in the home. client #5 did utilize his adaptive cup. Review on 5/9/18 of client #5's IPP dated 11/16/17 revealed he utilizes a weighted cup for drinking. During an interview on 5/8/18, the life skills specialist confirmed client #5 should have used his adaptive cup during medication administration. 4. Client #3 was not prompted to wear his eyeglasses on a consistent basis. During afternoon observations in the home on 5/8/18, the surveyor entered the home at 3:15pm. Further observaitons revealed client #3 putting on his eyeglasses at 3:58pm. Client #3 removed his eyeglasses at 5:08pm, put them on the dining room table and then began to eat his dinner. At	W 249		

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no time was client #3 prompted to put his eyeglasses back on.

During morning observations in the home on 5/9/18, the surrveyor entered the home at 6:49am. Further observations revealed client #3 did not have his eyeglasses on. At no time was client #3 prompted to put his eyeglasses on.

During an interview on 5/9/18, client #3 stated his eyeglasses were in his bedroom. When asked further questions about his eyeglasses, cleint #3 did not repsond.

Review on 5/9/18 of client #3's nursing evaluation dated 2/6/18 revealed, "Vision: Has bifocals - to be worn at al times per [doctors' name]."

Review on 5/9/18 of client #3's record revealed a nursing note dated 9/5/17 which stated, "a stigmatism; presbyopia RX eyeglass (bifocals) for full time wear...."

During an interview on 5/9/18, the QIDP confirmed staff should have prompted client #3 to wear his eyeglasses.

5. Client #6 was not offered her salad at dinner.

During dinner observations in the home on 5/8/18, client #6's dinner consisted of ham, collard greens, yams, corn bread and chocolate brownies. Staff did not offer client #5 any other food items to eat.

Review on 5/9/18 of client #6's nutritional evaluaton dated 1/31/18 stated, "...tossed salad with dressing at supper."

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W 249	Continued From page 9 During interview an interview on 5/9/18, the life skills specialist confrimed client #6 should have been offered a salad at dinner.	W 249		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to ensure client #1 received his annual physical and visual examinations. This affected 1 of 6 audit clients. The findings are: 1. Client #1 did not receive an annual physical. Review on 5/9/18 of client #1's current record revealed an annual physical examination dated 4/6/17. There was no current information available for review to indicate client #1 has received an annual physical examination since. During an interview on 5/9/18, the qualified intellectual disabilities professional (QIDP) confirmed client #1's annual physical examination should have been completed. 2. Client #1 did not receive an annual vision screening. Review on 5/9/18 of client #1's individual program plan (IPP) dated 6/1/17 stated, "[Client #1] last eye exam was on 4/10/17....Exam stated early cataracts and will need follow-up in one year."	W 323		

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W 323	Continued From page 10 During an interview on 5/9/18, the QIDP confirmed client #1's annual visual examination should have been completed.	W 323		
W 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain in a timely manner a dental examination for 1 newly admitted client (#3). The finding is: The facility failed to obtain a dental examination for client #3 within 30 days of admission. Review on 5/9/18 of client #3's individual program plan (IPP) dated 9/13/17 revealed he was admitted to the facility on 8/14/17. Further review of client #3's record revealed he had a dental examination on 12/7/17. During an interview on 3/6/17, the qualified intellectual disabilities professional (QIDP) stated she was unaware client #3's dental examination did not occurr within 30 days of admission.	W 351		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE	W 352		

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W 352	Continued From page 11 CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #6 received an annual comprehensive dental examination for the maintenance of her oral health. This affected 1 of 6 audit clients. The finding is: Client #6 did not have dental cleaning at least annually. Review on 5/9/18 revealed client #6 did not have a record of her annual dental examination. Further review did not indicate when client #6's last dental examination occurred. During an interview on 5/9/18, the facility's life skills specialist revealed client #6's went to the dentist on 3/2/18, but there was no indication of her treatment or diagnosis in her record.	W 352		
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 observations, record review and interviews, the facility failed to ensure the system of administrating medications as ordered was	W 368		

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W 368	Continued From page 12	W 368		

implemented. This affected 1 of 6 audit clients (#6). The finding is:

Client #6 did not receive her Miralax powder as ordered.

During medication administration on 5/9/18, the medication technician poured water into a white styrofoam cup and indicated with her hands the cup held eight ounces of water. Client #6 then, with hand over hand assistance, poured the Miralax powder in the cup.

During an interview on 5/9/18, the medication technician revealed she was told the styrofoam cups held eight ounces of water; just like the small drinking glasses the clients use at meal time. The surveyor obtained a measuring cup from the kitchen and filled it with water to the eight ounce line. The surveyor then poured the water from the measuring cup into another styrofoam cup to the top. There was still some water left in the measuring cup. The medication technician then obtained one of the small drinking glasses from the kitchen and turned it over to show "8 ounces" on the bottom. The medication technician then poured eight ounces of water (using the measuring cup) into the small drinking glass; it was filled to the top and there was still water left in the measuring cup. When asked, the medication technician confirmed the water was to the top of the glass and there was still water left in the measuring cup.

Review on 5/9/18 of client #6's physicians orders signed 3/23/18 revealed, "Polyethylene Powder Mix 17gm in 8 ounces of water."

During an interview on 5/9/18, the qualified

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W 368	Continued From page 13 intellectual disabilities professional (QIDP) revealed staff should have used a measuring cup to ensure client #6's Miralax was mixed with exactly eight ounces of water.	W 368		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to furnish a recommended specialized mattress. This affected 1 of 6 audit clients (#4). The finding is: Client #4 did not have a foam pressure relief mattress overlay with incontinence cover. During observations in the home on 5/918, it was revealed client #4 had a standard issed green mattress. Further observations revealed the mattress did not have a incontinence cover. Review on 5/9/18 of a physical therapy (PT) review for client #4 stated, "Recommendations:...6) Purchase and install foam pressure-relief mattress overlay with incontinence cover...." During an interview on 5/9/18, the qualified intellectual disabilites professional (QIDP)	W 436		

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	34G302	A. BUILDING _____ B. WING _____	05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 436	Continued From page 14 confirmed client #4 did no have the recommended foam pressure relief mattress overlay with incontinence cover.	W 436		