DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2018 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	34G302	B. WING			R 08/23/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	1 00/23/2010	
GE GROUP HOME			739 ARTHUR MADDOX ROAD SANFORD, NC 27330	1		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
0 INITIAL COMMENTS		W	000			
PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)		{W 1	25}			
*						
c. Review 5/9/18 of c	client #6's record revealed a					
	ROVIDER OR SUPPLIER SE GROUP HOME SUMMARY ST. (EACH DEFICIENC REGULATORY OR INITIAL COMMENTS) INITIAL COMMENTS PROTECTION OF CICCFR(s): 483.420(a)(3) The facility must ensumed the facility individual clients to expect of the facility, and as including the right to the facility individual clients to expect of the facility, and as including the right to the facility of the facility, and as including the right to the facility of the facility, and as including the right to the facility of the facility of the facility of the facility clients (#1, #3, #4, #6, addressed by their leconsent obtained by the findings are: 1. Consents were not guardians for clients: a. Review on 5/9/18 revealed a behavior so 12/26/17. Further revealed a behavior so 12/26/17. Further revealed he does not consent signed by his some consent signed supplies the consent signed some	ROVIDER OR SUPPLIER SE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS 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 on observations, 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.	ROVIDER OR SUPPLIER SE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G302	B. WING			R	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 739 ARTHUR MADDOX ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	X (EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{W 125}	BSP dated 12/30/17. client #6's behavior m Onfi. Additional revier revealed her BSP conductor of the behavior montellectual disabilities confirmed clients #1 as BSP consent for the their legal guardians. client #6's consent for had expired.	Further review revealed nedications are: Abilify and ew of client #6's record neent expired on 4/4/17. In 5/9/18, the qualified a professional (QIDP) and #3 records did not have beir medications signed by The QIDP also confirmed or her behavior medications 8/23/18, the above W tag	{W 1	25}			