STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop and maintain an emergency preparedness (EP) plan to include a risk assessment based on an all-hazards approach and failed to develop specific facility-based strategies and specific client information. The finding is:	E 006		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 006	Continued From page 1 Review conducted on 10/30/18 of Section 2.01 of the facility's Adult Residential Services Manual, titled Emergency-Disaster Plan, revealed the plan was approved by the Executive Committee on 12/1/15 and included general information for EP; however, no information specific to clients residing in the group home or information relative to the geographic location of the group home was included. Interviews conducted on 10/30/18 and 10/31/18 with the qualified intellectual disabilities professional and interviews conducted on 10/31/18 with the administrator revealed the facility's EP plan had not been updated since 12/1/18 and specific information was not included relative to the geographic location of the home or client-specific information that would enable persons unfamiliar with the clients to provide the needed assistance.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must	E 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 013	Continued From page 2	E 013		

develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.

*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.
This STANDARD is not met as evidenced by:
Based on review of facility documents and staff interviews, the facility failed to ensure policies and procedures were developed and updated based on the facility's emergency preparedness (EP) plan. The finding is:

Review conducted on 10/31/18 of Section 2.01 of the facility's Adult Residential Services Manual, titled Emergency-Disaster Plan, revealed the plan was approved by the Executive Committee on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 013	Continued From page 3 12/1/15 and included general information for emergency preparedness; however, the EP plan did not include current policies and procedures regarding the emergency plan, risk assessment and the communication plan. Interviews conducted on 10/30/18 and 10/31/18 with the qualified intellectual disabilities professional and the administrator on 10/31/18 verified the EP plan did not include current policies and procedures relative to the facility's emergency response plan.	E 013		
E 029	Development of Communication Plan CFR(s): 483.475(c) (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. This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness including a specific communication plan that complies with federal, state and local laws and is updated at least annually. The finding is: Review conducted on 10/30/18 of Section 2.01 of the facility's Adult Residential Services Manual, titled Emergency-Disaster Plan, revealed the plan was approved by the Executive Committee on 12/1/15 and included general information for emergency preparedness; however, the emergency preparedness (EP) plan did not include current policies and procedures regarding communication means (primary or alternate)	E 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 029	Continued From page 4 during any emergency/disaster situation. Interviews conducted with the qualified intellectual disabilities professional and administrator revealed the current EP plan has not been updated since 12/1/15, and does not contain current information relative to primary or alternate means of communication during an emergency/disaster situation.	E 029		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. 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 a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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	Continued From page 5 community-based or individual, facility-based. (B) A tabletop exercise that includes 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. (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 RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] 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 and 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. This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility failed to ensure facility/community-based or tabletop exercises to test the current emergency preparedness (EP) plan were conducted. The finding is: Review conducted on 10/30/18 of Section 2.01 of the facility's Adult Residential Services Manual, titled Emergency-Disaster Plan, revealed the plan	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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	Continued From page 6 was approved by the Executive Committee on 12/1/15 and included general information for emergency preparedness; however, the EP plan did not include a full-scale community-based or individual facility-based exercise or tabletop exercise to test their emergency plan. Interviews conducted 10/31/18 with the qualified intellectual disabilities professional and the administrator verified the facility had not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure privacy was maintained for 1 sampled client (#2). The finding is: Throughout observations in the group home during the survey period 10/30/18 to 10/31/18 revealed client #2's bedroom window to have no window covering. Further observations revealed a visible tinted film on a small, lower portion of client #2's bedroom window pane. Continued observations of client #2's bedroom window revealed a clear, unobstructed side view of the home located next door. Interviews conducted with staff (3) throughout the survey period 10/30/18 to 10/31/18 revealed	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 130	Continued From page 7 client #2 has a behavior of tearing down his bedroom window coverings and his bedroom window covering has been off for about one week. Continued interviews revealed client #2 tore off his bedroom window covering last week. Review on 10/31/18 of client #2's behavior support plan (BSP) dated 5/26/18 revealed an objective to "reduce episodes of disruptive behaviors during which a target behavior is displayed to no more than 6 episodes per month for 6 consecutive months." Continued review revealed the following target behaviors: aggression, property destruction/misuse, noncompliance/resistance, self injurious behavior, and elopement. Interview with the qualified intellectual disabilities professional (QIDP) verified all clients including client #2 should have window coverings on their bedroom window(s) to ensure privacy.	W 130		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: The facility failed to assure the individual program plan (IPP) for 1 of 3 sampled clients (#2) included objective training to meet the client's behaviors as evidenced by observation, interview and record verification. The finding is:	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 227	Continued From page 8 Throughout observations in the group home during the survey period 10/30/18 to 10/31/18 revealed client #2's bedroom window to have no window covering. Further observations revealed a visible tinted film on a small, lower portion of client #2's bedroom window pane. Continued observations of client #2's bedroom window revealed a clear, unobstructed side view of the home located next door. Interviews conducted with staff (3) throughout the survey period 10/30/18 to 10/31/18 revealed client #2 has a behavior of tearing down his bedroom window coverings and his bedroom window covering has been off for about one week. Continued interviews revealed client #2 tore off his bedroom window covering last week. Review on 10/31/18 of client #2's IPP dated 2/26/18 revealed the following programs: purchase an item in the community, exercise social distance, knock before entering bedroom or bathroom, engage in home/community/physical/medication activities, prepare a side item, brush his teeth, complete chores, wash hands, expand social skills/interests, and use picture cards to communicate when outside the home. Review on 10/31/18 of client #2's behavior support plan (BSP) dated 5/26/18 revealed an objective to "reduce episodes of disruptive behaviors during which a target behavior is displayed to no more than 6 episodes per month for 6 consecutive months." Continued review revealed the following target behaviors: aggression, property destruction/misuse, noncompliance/resistance, self injurious behavior, and elopement.	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 227	Continued From page 9 Interview with the qualified intellectual disabilities professional (QIDP) revealed client #2 will also tear down any of the home's window coverings. Additional interview with the home manager and the QIDP verified client #2 currently has no objective training to address his behavior of tearing down window coverings.	W 227		
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: The facility's system for ensuring drugs were administered in compliance with physician's orders failed for 1 of 3 sampled clients (#1) observed as evidenced by observations, interview and review of records. The finding is: Observations in the group home of medication administration on 10/31/18 at 7:35 AM revealed client #1 received Fexofenadine, Oxybutynin, Eliquis, Escitalopram, Depakote, Perphenazine, and Vitamin D. Review on 10/31/18 of the physician's orders dated 9/1/18 to 9/30/18 revealed client #1 is to also receive "Chlorhexidine Gluc 0.12% Soln Dip toothbrush and use to clean mouth twice a day (Do not swish or swallow)" at 8 AM and 8 PM. Interview on 10/31/18 with the home manager revealed client #1 received his Chlorhexidine Glu 0.12% Soln at 6 AM. Continued interview	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 368	Continued From page 10 revealed client #1 receives his Chlorhexidine Gluc 0.12% Sol at 6 AM every morning along with any prescribed topicals. Review on 10/31/18 of the 9/1/18 to 9/30/18 physician's orders and verified by the home manager and the qualified intellectual disabilities professional (QIDP) revealed client #1 should receive his Chlorhexidine Gluc 0.12% Soln as prescribed.	W 368		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure only authorized persons had access to the keys to the drug storage area. The finding is: Observations conducted on 10/30/18 at 4:50 PM revealed staff retrieved the keys to the drug storage closet from an unsecured drawer in the kitchen and opened the door to the drug storage area. Staff was then observed to hang the keys to the drug storage area, which included the key to the closet door as well as the key to the controlled drug storage area, over the doorknob on the outside of the drug storage/administration closet. Further observation conducted at 5:05 PM revealed the house manager took the keys from the outside door knob and entered the drug storage area to review the drugs which had been administered by staff. The house manager was then noted to exit the drug administration area	W 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G113	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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 383	Continued From page 11 and replace the keys in the unsecured kitchen drawer. Observation conducted on the morning of 10/31/18 at 7:15 AM revealed staff retrieved the keys to the drug administration area from the unsecured drawer in the kitchen and opened the door to the drug administration area. Staff was then noted to perform the morning drug administration process from 7:15 AM to 7:55 AM at which time the keys were returned to the unsecured drawer in the kitchen where they remained throughout survey observations. Observation of the contents of the kitchen drawer where the keys were located revealed several sets of keys and various household items. Interview conducted with the group home manager, conducted on 10/31/18 at 9:00 AM verified the keys were currently being kept in the kitchen drawer when not in use. This interview further revealed the keys to the drug storage area should always be kept on the person of the staff responsible for drug administration.	W 383		