STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G252	A. BUILDING _____ B. WING _____	11/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGELY OAK	1307 WESTRIDGE RD GREENSBORO, NC 27410

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy, budget and operating direction over the facility by failing to assure damage to the front hall group home bathroom was repaired in a timely manner. The finding is: Observations in the group home on 11/13/18 at 4:45PM revealed the front hall bathroom with large areas of damaged wall with mold measuring approximately 1' x 2' along the base board and shower area. Continued observation revealed the pedestal sink in the same bathroom had a towel at its base that was wet. Interview with the group home manager revealed that the damaged wall/baseboard area and the leaking sink in the bathroom had been reported to administration and put on a repair list for several months, however no repairs had been made to either. Interview with the facility qualified intellectual disabilities professional (QIDP) on 11/14/18 confirmed that the areas of damage in the group home bathroom had been reported several times over the past year, with no repairs made to date. Therefore the governing body failed to assure damages were repaired in a timely manner.	W 104		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)	W 227		

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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W 227	Continued From page 1 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: Based on record review and interview the facility failed to ensure the person centered plans (PCP's) for 2 of 4 sampled clients (#3) and (#4) included objective training to address identified needs relative to property damage and privacy. The findings are: A. The facility failed to assure objective training was developed to meet client #3's behavioral needs related to property damage. Observations in the group home during the 11/13-11/14 survey revealed property damage of 2 areas of the dining room walls measuring approximately 7"x10" each. Interview with the group home manager revealed that client #3 had punched the wall areas causing the damage "when he did not get his way or what he wanted." Continued interview with the group home manager revealed that client #3 also broke his bedroom window within the last few weeks when he was frustrated over "not having a TV in his room." Record review of client #3's PCP dated 01/23/18 revealed a behavior support plan (BSP) dated 4/1/18 with guidelines to address self injury and helping client #3 to stay calm. Continued review of the BSP revealed no goal has been developed to address the client's behaviors related to property damage.	W 227		

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W 227	Continued From page 2 Interview with the facility qualified Intellecutual disabilities professional (QIDP) on 11/14/18 confirmed no goal has been developed to address client #3's behaviors related to property damage. B. The facility failed to assure objective training was developed to meet client #4's privacy needs. Observations in the group home on 11/14/18 revealed client #4 toileting with the bathroom door open for approximately 4 minutes from 8:36AM-8:40AM in a bathroom adjacent to the den area, a common area where other clients come and go. Continued observations revealed client #4 called for staff assistance during this period of time, leaving the door open until staff arrived to assist him at 8:41AM. Interview with the group home staff revealed client #4 often opens the bathroom door while toileting, calls for staff to assist him, leaving the door open until staff arrives to assist him. Record review for client #4 on 11/14/18 revealed a PCP dated 3/29/18. Continued review of the PCP revealed client #4 does not have training objective to address his privacy needs. Interview with the facility QIDP on 11/14/18 confirmed client #4 currently does not have a training objective to address his privacy needs.	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.	W 368		

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W 368	Continued From page 3 This STANDARD is not met as evidenced by: The facility's system for teaching clients to administer their own medications failed for 2 of 2 sampled clients (#3 and #4). The findings are: A. The facility system for teaching clients to administer their own medication failed for client #3. Observations in the group home on 11/14/18 from 7:40 AM to 7:50 AM revealed client #3 received Lexapro, Atarax Zyprexa, NAC and Trilitexine? for his morning medications. Continued observations of the medication pass revealed client #3 to participate by punching his medications and taking his medication with juice as instructed. Further observation of the medication pass revealed there was no teaching by staff about the name of medications for client #3, what the medications were being taken for, and what the possible side effects could be. B. The facility system for teaching clients to administer their own medications failed for client #4. Observation in the group home on 11/14/18 at 8:50 AM revealed client #4 to receive Calcium, Myrbetriq ER, Senna, Flomax, Vitamin D3, Vitamin B12, Systane eye drops, and polyethylene glycol powder in 8 ounces of water. Continued observation revealed client #4 to punch his medications and stir his powder in his water. Further observation of the medication pass revealed there was not teaching by staff about the name of medications for client #4, what the medications were being taken for, and what the possible side effect of medications could be.	W 368		