STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G232	A. BUILDING _____ B. WING _____	02/12/2019

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NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

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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 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.	E 039		

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

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E 039	Continued From page 1 *[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 document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 2/12/19 of the facility's EP plan (dated 2018) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 2/12/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop	E 039		

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E 039	Continued From page 2 exercise to test the effectiveness of their current emergency plan.	E 039		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on reviews and interviews the facility failed to assure outside services meet the needs of each client. This affected all the clients residing at the home. The finding is: Clients did not have individual program plans (IPP) available at the home. During review on 2/11/19 of all clients' record at home revealed no client had an individual program plan (IPP) on file at the home. During an interview on 2/12/19, with the Qualified Intellectual Disabilities Professional (QIDP) and home management confirmed all client did not have current IPP at home since the charts are kept in the office.	W 248		
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	W 249		

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W 249	Continued From page 3 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, interviews and record reviews, the facility failed to ensure 2 of 4 audit clients (#2, #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 adaptive equipment use. The finding is: Client #2's, #6's adaptive equipments were not utilized as indicated in the IPP. During lunch observations in the home on 2/11/19, client #2 and #6 consumed their meals without utilizing a dycem mat. Both client plates were not stable during the meals Review of client #2's individual program plans (IPPs) dated 9/18 revealed,"Dycem mat during meals. Review of client #6's IPP dated 9/25/18 revealed, "Use dycem mat during meals." Staff interview on 2/12/19 revealed client #2 and #6 dycem mats should be used with all meals. Interview on 2/12/19 with the qualified intellectual disabilities professional (QIDP) confirmed client #2's and #6's mat are supposed to be utilized during all meals.	W 249		

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W 288	Continued From page 4	W 288		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure a technique to manage client #3's moods was included in a formal active treatment plan. This affected 1 of 4 audit clients. The finding is: The use of Trazadone was not included in client #3's active treatment plan. Review on 2/12/19 of client #3's physician's orders dated 11/14/18 revealed the client ingests Trazadone 50 mg by mouth every night for sleep. Additional review of the client's record did not include a formal treatment plan which incorporated the use of Trazadone. Interview on 2/12/19, with the Qualified Intellectual Disabilities Professional (QIDP) confirmed she was not aware that client #3 ingest Trazadone for sleep. The QIDP acknowledged the medication should be included in a formal active treatment plan.	W 288		
W 313	DRUG USAGE CFR(s): 483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh	W 313		

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W 313	Continued From page 5 the potentially harmful effects of the drugs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a drug used for the control of client #3's inappropriate behavior was used only after the potentially harmful affect of the behaviors outweigh the harmful affect of the drug. This affected 1 of 4 audit clients. The finding is: Client #3's behavior data did not support the use of psychotropic medication. Review on 2/11/19 of client #3's record revealed a behavior support plan (BSP) the client to exhibit one or fewer challenging behavior per month for eleven (11) consecutive months. Additional review of client #3's current physician's orders dated 11/14/18 indicated an order for Celexa 40mg once a day, Trazadone 50mg once at bedtime, Lithium 300mg twice a day, Fanapt 12mg twice a day, Klonopin 1mg 4X a day, Thorazine twice a day all the above medication were prescibed for behavior. Further review of monthly progress notes from January '18 - November '18 revealed the client had exhibited 0 targeted behaviors and over 16 months. Additional review of the record did not indicate the interdisciplinary team had discussed the continued use of the drug in relation to client #3's behavior data. Interview on 2/12/19 with the program coordinator confirmed the team had not discussed client #3's continued use of psychotropic medication in relation to the lack of significant behaviors over nearly 16 months.	W 313		

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W 350	DENTAL SERVICES CFR(s): 483.460(e)(3) The facility must provide education and training in the maintenance of oral health. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure training was provided for the maintenance of the clients' oral health. This affected 1 of 4 audit clients (#5). The finding is: Training was not provided to address improving client #5's oral health. Review on 2/12/19 of client #5's dental report dated 11/19/18 revealed, "condition of gum fair, " with a recommendation to help brush at least twice daily and floss as often as possible. Review on 2/12/19 of client #5's individual program plan (IPP) dated 1/30/19 revealed, client #5 does not have a current training objective to improve his oral health. Interview on 2/12/19, the qualified intellectual disabilities professional (QIDP) revealed no training has been provided for client #5 and/or staff since his dental visit on 11/19/18. The QIDP acknowledged more training is needed.	W 350		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interviews and record reviews the	W 440		

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W 440	Continued From page 7 facility failed to assure that fire drills occurred one per shift per quarter. This potentially affected all clients living in the home. The finding is: The fire drills were not conducted one per shift per quarter. Review on 2/11/19 of the fire drill reports revealed there was not drill for first shift between rhe month of April 18'- Jan 2019'. During an interview on 2/12/19, with the Qualified Intellectual Disabilities Professional (QIDP) and home management confirmed the fire drill should be conducted quarterly per shift.	W 440		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills were not conducted at varied times. Review of fire drill reports on 2/11/19 revealed the following: Fire drills on 3rd shift at the following times: 6:00am, 6:28am, 7:00am, and 6:30am. During an interview on 2/1219, the qualified intellectual disabilities professional (QIDP)	W 441		

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W 441	Continued From page 8 revealed 3rd shift hours are 12 midnight - 8:00am. The QIDP confirmed the fire drills on 3rd shift were not varied.	W 441		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is: Food substitutions were not documented. During lunch observations in the home on 2/11/19, staff substituted mixed vegetable, chicken and rice for tuna salad on wheat bread, lettuce, tomato, pickle, pineapple and baked cheese puff. Staff was not observed documenting the food substitution. Review of the facility's lunch substition log did not reveal documentation of any meal during this year. During an interview on 2/11/19, the home manager confirmed client always pack the dinner left over for lunch. During interview with with the Qualified Intellectual Disabilities Professional (QIDP) confirmed, the substitution log should be documented.	W 481		