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

PRINTED: 02/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 02/12/2019
NAME OF PROVIDER OR SUPPLIER: NORTHRIDGE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE: 88 MITCHELL FORD ROAD CLARKTON, NC 28433	

(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	EP Testing Requirements CFR(s): 483.475(d)(2)	E 039		
	(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 The Facility will assure a mock natural or man-made emergency is conducted annually for each staff and individual. QP and Program Manager will monitor annually. Full evacuation was executed during Hurricane Florence in September 2018 RECEIVED APR 02 2019 DHSR-MH Licensure Sect	4-12-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ICF Division Director (X6) DATE: 4-2-19

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
	34G232	A. BUILDING ______ B. WING ______	02/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	86 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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		

9106428039 12:33:53 p.m. 04-02-2019 4/11

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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 248 The facility will assure That each staff receives training on each individual IIP Plans. QP will in-service all staff on each individuals IPP Plans. Copies of IPP's will be kept at the home. QP will monitor monthly.	4-12-19
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	W 249 The facility will assure all staff Is trained on diets and adaptive equipment. Program Manager and Habilitation Specialist will monitor weekly and QP monthly.	

9106428039 12:34:15 p.m. 04-02-2019 5/11

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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		

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

PRINTED: 02/21/2019
FORM APPROVED
OMB NO. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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 288 The facility will assure that all medications used for behavior control were integrated into an active treatment program. QP will have clients #4 BSP signed by guardian and in-service all staff members. QP will monitor monthly.	4-12-19
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		

9106428039 12:35:01 p.m. 04-02-2019 7/11

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 313	Continued From page 5 the potentially harmful effects of the drugs.	W 313	W 313 Interdisplinary team will assess and reassess all clients' behavior plans, Psychologist notes for Psychiatrist to determine medication changes if needed.	4-12-19
	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.			

12:35:25 p.m. 04-02-2019 8/11 9106428039

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

PRINTED: 02/21/2019
FORM APPROVED
OMB NO. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	98 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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 350 The facility will assure that training is provided for maintenance of individuals oral health QP and Life Skills Specialist will meet revise individuals dental Objective to address the poor dental report and in-Service all staff members on the changes. Program Manager and Life skills specialist will monitor weekly And QP will monitor monthly.	4-12-19
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		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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 440 The facility will assure evacuation drills are at least Completed quarterly for each shift. QP will ensure that Evacuation drills are conducted one fire drill per shift Program Manager and QP will monitor monthly.	4-12-19
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	W 441 The facility will assure evacuation drills be done While individuals are asleep. Drills will be completed on each shift. QP will assure that evacuation drills are conducting One fire drill per shift including while individuals are asleep. Program Manager and QP will monitor monthly.	

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

PRINTED: 02/21/2019
FORM APPROVED
OMB NO. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 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	W 481 The facility will assure all food substitutions are documented. Program Manager will in-service staff on the proper way to document food substitutions. Program Manager will monitor weekly. QP will monitor monthly	4-12-19

11/11 04-02-2019 12:36:36 p.m. 9106428039