Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN OF CORRECTION			A. BUILDING:				
MHL092-676		B. WING		R 04/09/2019			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
RALPH DRIVE HOME 413 RALPH DRIVE							
		CARY, NO					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An Annual and Follow 04/09/19. A deficience	Up Survey was completed y was cited.					
	This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.						
V 290	10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with		V 290				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2 / 2.11 0.1 00.11.20.110.1			A. BUILDING:			
		MHL092-676	B. WING		R 04/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	DIVE HOME	413 RALPI	I DRIVE			
KALPH DI	RIVE HOME	CARY, NC	27513			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 290	need be present during specified by the emery determined by the go (d) In facilities which diagnosis is substance (1) at least one duty shall be trained in withdrawal symptoms secondary complication drug addiction; and	However, only one staffing sleeping hours if regency back-up procedures verning body. serve clients whose primary the abuse dependency: a staff member who is on a lacohol and other drug and symptoms of ons to alcohol and other. Is of a certified substance I be available on an	V 290			
	failed to ensure to material enable the staff to metalents (#1-#4). The fill revealed; - Client #1: admindiagnosis including produced pomental disabit Dandy Walker Syndroneeds assistance with hygiene. - Client #3: admindiagnosis of severe II Hypothyroidism. He is early signs of dementiced the staff to me and the staff to m	ew and interview the facility aintain staff client ratios to set the needs of four of four andings are: of 3 of 3 audited clients ssion date 10-19-85 and rofound intellectual and lities (IDD) Bell Palsy and ome. He is non-verbal, in safety awareness and sesion date 10-18-85 and DD, Down Syndrome and its non-erbal and showing tia. ssion date 08-25-16 and				
	abnormality, cleft pala	ate, Hypoglycemia, hearing drome, Diabetes and febrile				

Division of Health Service Regulation

STATE FORM 5899 5MY311 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL092-676		B. WING	B. WING					
MHL092-676 B. WING 04/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
RALPH DRIVE HOME 413 RALPH DRIVE CARY, NC 27513								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
V 290	seizures. He is non-variet treatment plan Februar aggression property Review on 04-05-19 or revealed single cover following dates: -March 9,12,15,1 -April 2,3,4, During and interview Coordinator reported on second shift is 2:4 possible recently due During interviews on Qualified Professional interviews to find staff positions.	verbal and required a lary 2019 to address destruction and tantrums. of schedule documentation age on second shift on the 6,21,23,24,25,26,27,28,31 on 04-04-19 the Program that the expected staff ratio but this has not been to staff shortage. 04-04-19 and 04-05-19 the I reported they are in fing to fill the vacant	V 290					

Division of Health Service Regulation

STATE FORM 5899 5MY311 If continuation sheet 3 of 3