STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(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.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Emergency Preparedness (EP) plan included information regarding an alternative means of communicating with facility staff, federal, state, regional and local emergency management agencies. The finding is: Information to address an alternative means of communication to be used in the event of an emergency was not included in the EP. Review on 6/5/19 of the facility's EP plan (updated 4/3/18) did not include information regarding an alternative means of communication in the event of a power failure. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the	E 032		

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

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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E 032	Continued From page 1 home has a cell phone which could be used in emergencies and staff have permission to utilize their personal cell phones at that time. The QIDP acknowledged this information should be included in the facility's EP plan to address alternative means of communication. At the time of this interview, the QIDP indicated the facility's cell phone could not be located.	E 032		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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E 037	Continued From page 2 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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E 037	Continued From page 3 arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff,	E 037		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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E 037	Continued From page 4 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Staff had not been trained on the facility's EP plan. Review on 6/5/19 of the facility's EP plan (updated 4/3/18) did not include any information regarding training of staff. During an interview on 6/5/19, the Qualified Intellectual Disabilities Professional (QIDP) revealed staff had not been retrained on the facility's EP plan since the plan was initiated.	E 037		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

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E 039	Continued From page 5	E 039		
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	E 039		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

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E 039	Continued From page 6 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 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 6/5/19 of the facility's EP plan (updated 4/3/18) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the	E 039		

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E 039	Continued From page 7 facility has 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 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure outside services met the needs of 2 of 3 audit clients (#4, #5). The findings are: 1. At the day program, client #4 was served food and drinks which did not meet his appropriate diet texture and staff did not follow his feeding guidelines. During observations of lunch at the day program on 6/4/19 at 12:00 pm, client #4 was being assisted with his meal by day program Staff F. Client #4 had a sectioned plate that contained a blended pasta casserole that had small chunks of green vegetables in it, smooth pureed orange jello and squash. In a Styrofoam cup was a red beverage. Client #4 only showed interest in drinking the red beverage. At 12:25 pm, Staff F filled client #4's cup with water and added 2 scoops of thickener, stirring the contents and offered it to client #4 who starting to drink from the cup. At 12:30 pm, client #4 was observed to cough repeatedly while finishing his drink. Staff F patted client #4 on his back, as client #4 hung his	W 120		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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W 120	Continued From page 8	W 120		

head low while seated. Client #4 was offered his food, refusing to eat the pureed squash and jello. Client #4 started to eat the pasta and was not prompted to take sips of beverage between bites. At 12:43 pm, client #4 started to cough after taking a bite of the pasta and was not offered anything to drink.

Review on 6/4/19 of the Annual Nursing Summary dated on 2/21/19 revealed that client #4 was on a pureed diet with thicken liquids, due to a choking incident in March 2014. Client #4 was noted by the nurse to be an aspiration risk. Additional review of the physician's orders signed 3/22/19 revealed that client #4 was on a pureed diet with nectar consistency and should take small bites with sips.

Interview on 6/4/19 with Staff F revealed that the group home did not send a consistent pureed texture, when preparing pasta or meat items in client #4's lunch. Staff F shared that today, it did not appear that client #4 was given a pureed texture with his pasta dish. In the past, the classroom has had to use their blender to further process client #4's food before offering it to him. On other occasions Staff E has called the group home and informed them that the diet texture was not consistent with pureed diet. Staff F also commented that when she attempted to thicken client #4's drinks to a nectar texture, she tried to have the beverage resemble a "slushie drink". Staff F stated that she had not received any written instructions on his (client #4's) feeding protocol and that most of the times she used 1 to 2 scoops of thick-it powder or added water when needing to thin out the drink.

Interview on 6/5/19 with the Quality Intellectual

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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W 120	Continued From page 9 Disabilities Professional (QIDP) revealed that she could only recall getting one call from the day program about six months ago that client #4 did not receive an appropriate pureed texture for lunch. The QIDP shared that she has not given the day program staff any specific instructions on how to achieve a pureed texture and that staff should alternate sips with bites. 2. Client #5 was fed during lunch at the day program. During lunch observations at the day program on 6/4/19 at 12:05pm, client #5 was initially noted to feed himself independently using a built-up handle spoon. At 12:25pm, Staff E approached the client and asked, "Do you want me to do it for you?" Staff E then retrieved the adaptive spoon and began feeding client #5 the remainder of his lunch meal. Review on 6/4/19 of client #5's IPP dated 11/16/18 revealed he eats with minimal physical assistance. Interview on 6/5/19 with the QIDP indicated client #5 can feed himself with minimal assistance needed and he should not have been fed by staff. 3. Client #5's adaptive cup was not utilized at the day program. During lunch observations at the day program on 6/4/19 at 12:05pm, client #5 drank from a Styrofoam cup and a small drink jug. While using the Styrofoam cup, the client bit a chunk out of the rim of the cup. Review on 6/4/19 of client #5's Individual	W 120		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 120	Continued From page 10 Program Plan (IPP) dated 11/16/18 revealed, under adaptive eating equipment, the client utilizes a "weighted cup". Interview on 6/5/19 with the QIDP confirmed client #5 should use an adaptive cup at meals and his dining equipment should be available at the day program. 4. Client #5 wore a clothing protector during lunch at the day program. During lunch observations at the day program on 6/4/19 at 12:05pm, client #5 wore a clothing protector secured around his neck as he consumed his meal. Review on 6/4/19 of client #5's IPP dated 11/16/18 did not indicate the client required a clothing protector at meals. Interview on 6/5/19 with the QIDP revealed client #5 does not wear a clothing protector at meals in the home and should not have needed one at the day program.	W 120		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 audit clients (#2, #4) had the right to clothing of an	W 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

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W 137	Continued From page 11 appropriate size and fit. The finding is: 1. Client #2's jeans did not fit him properly. During observations throughout the survey at the day program and in the home on 6/4/19, client #2 wore jeans which were loose around his waist and baggy. Each time the client stood from a seated position, his pants slipped down exposing his underwear and buttocks. As the client walked to various areas of the day program and home, he consistently and repeatedly held up his pants with one hand to prevent them from falling down. The client was observed to perform various tasks like setting the table and clearing his dishes while holding up his jeans with one hand. Although client #2 wore a belt, his jeans continued to slip down. Client #2 was not prompted or assisted to change his jeans and left the home at 5:58pm on a community outing. Review on 6/5/19 of client #2's Individual Program Plan (IPP) dated 7/3/18 revealed he requires prompts to "fully dress". The plan also identified a need with putting on his clothing. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed his mother usually purchases client #2's clothing for him and without him trying them on. 2. Client #4 was dressed in lose fitting pants that fell down. During observations at the day program and home on 6/4/19, client #4 wore two different pairs of shorts that were lose fitting and fell to his ankles. Initially at the day program, client #4 wore a size 32 khaki shorts without a belt. During the	W 137		

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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W 137	Continued From page 12 meal, client #4 stood up from this chair, which caused his shorts to fall to the floor, revealing an incontinence brief. There were nine clients and three staff present in the classroom when this happened. Staff F pulled up client #4's shorts, then took the narrow cloth gait belt from around his waist and placed it through the belt loops on his shorts. The gait belt was replaced around client #4's waist. Next, when client #4 stood to be transferred to the wheelchair, he was able to pull his shorts down, exposing his brief. When Staff G walked client #4 to the table, his shorts started to slide down his thighs, creating some sagging with the incontinence brief. An additional observation at the home at 5:45 pm, revealed client #4 was now wearing a nylon athletic short, with drawstring waist band, as he sat at the dinner table. When client #4 stood, he would pull down his shorts, which prompted Staff A to pull the shorts back up and hold onto client #4's waistband. After client #4 finished his meal, Staff C took him back to his room and changed his clothes to nylon athletic shorts, which fit better. Review on 6/4/19 of client #4's IPP dated 11/21/18 revealed that he needed minimum assistance when putting clothes on. Interview on 6/5/19 with the QIDP revealed that clients clothes would be examined and/or replaced for best fit.	W 137		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

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W 189	Continued From page 13	W 189		

employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure all staff were sufficiently trained to implement client #4's appropriate food/drink consistency, feeding guidelines and to safely load/secure wheelchairs on the van. This affected 2 of 3 audit clients (#4, #5). The findings are:

1. Client #4's appropriate food and drink consistency or his feeding guidelines were not followed at 3 of 3 meals.

a. During observation of lunch at the day program on 6/4/19 at 12:00 pm, client #4 was being assisted with his meal by day program Staff F. Client #4 had a sectioned plate that contained a blended pasta casserole that had small chunks of green vegetables in it, smooth pureed orange jello and squash. At 12:25 pm, Staff F filled client #4's cup with water and added 2 scoops of thickener, stirring the contents and offered it to client #4 who starting to drink from the cup. At 12:30 pm, client #4 was observed to cough repeatedly while finishing his drink. Staff F patted client #4 on his back, as client #4 hung his head low while seated. Client #4 started to eat the pasta and was not prompted to take sips of beverage between bites. At 12:43 pm, client #4 started to cough after taking a bite of the pasta and was not offered anything to drink.

b. During observations in the home on 6/4/19 at 4:52 pm, the blender contained peas and carrots with no liquid added. Staff D turned on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 189	Continued From page 14	W 189		

blender for about 20 seconds and blended the food. There were still noticeable green and orange small chunks of the vegetables, as Staff D transferred the food on the sectioned plate. Next, Staff D scooped chicken and dumplings with broth into the blender, and processed the food for less than 10 seconds, with some visible vegetables remaining in the pureed texture. The food was presented to client #4, who would not eat anything except for the chocolate pudding. After client #4 ate the pudding, Staff A placed 4 scoops of thickener into a 4 ounce cup of tea and offered it to client #4, but he did not take any sips. Instead client #4 took a few bites of the chicken and dumplings. At 5:28 pm, Staff A put the glass of tea in front of client #4 but did not verbally prompt him to take sips. Client #4 reached for the glass of tea and took several sips, before he was led out of the room for a wardrobe change.

c. During observations in the home on 6/5/19 at 6:20 am, Staff C had just finished using the blender to puree the oatmeal for client #4's breakfast. At 6:28 am, client #4 sat next to Staff J who has already scooped an undetermined amount of thickener in a 6 ounce glass of tea and was stirring the contents. Client #4 had a section plate with smooth pureed scrambled eggs and french toast sticks and lumpy oatmeal with pieces of blueberries. Client #4 started to feed himself, eating the oatmeal. At 6:38 am, Staff J asked Staff K if there were blueberries in the oatmeal and Staff K responded that it contained blueberries and bananas. Client #4 did some infrequent coughing as he continued to eat his meal and Staff J patted him on his back. Client #4 did not take any sips of fluids during his meal and was not prompted by staff. Client #4 went to sit down in a chair, after eating breakfast. Staff J

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 189	Continued From page 15	W 189		

brought the tea to him and also prepared a 4 ounce cup of milk that had 2 tablespoon of thickener placed in it. Client #4 drank the tea, then drank his milk. The container of unflavored thickener was examined. It stated to reach nectar consistency, 4-5 tablespoon should be added to the beverage and then allow the beverage to sit for 30 seconds. The instructions did not specify if adjustments should be made based on the amount of fluid ounces in the glass.

Review on 6/4/19 of the Annual Nursing Summary dated on 2/21/19 revealed that client #4 was on a pureed diet with thicken liquids, due to a choking incident in March 2014. Client #4 was noted by the nurse to be an aspiration risk. Additional review of the physician's orders signed 3/22/19 revealed that client #4 was on a pureed diet with nectar consistency and should take small bites with sips.

Review on 6/5/19 of client #4's Speech Language Pathology Initial Evaluation dated 2/19/19- revealed that client #4 was diagnosed with oropharyngeal dysphasia (swallowing disorder) and that clinical rick factors for aspiration that were present during the assessment, was that he produced a wet/aphonic vocal quality (inadequate voice support to produce intelligible speech) after swallowing. Factors compounding risk of aspiration was client #4's cognitive deficits and dependence on feeding. Observations included that client #4 had prolonged oral holding of pureed intake. He had questionable wet vocal quality but otherwise had no signs or symptoms of aspiration. Client #4 had 7 more pureed trials by 2/21/19 and was discontinued from speech language pathology treatment after demonstrating no overt signs or symptoms of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 189	Continued From page 16	W 189		

aspiration. It was recommended that client #4 should alternate solids and liquids, and take small bites and sips.

An additional review on 6/4/19 of the Dietary Inservice dated 4/7/18, which hung on the facility's kitchen wall, revealed that when preparing a modified diet of pureed consistency, food is smooth, moist and lump free; may have a grainy texture; thickened liquids at nectar thick, fluid runs freely off the spoon but leaves a mild coating on the spoon. When using a thickening powder or thickening agent, staff were to follow the instructions on container. It further added that signs and symptoms of choking, include struggling to breathe (gasping), coughing, gagging, and bluish lips or skin.

Interview on 6/4/19 with day program Staff F revealed that the group home did not send a consistent pureed texture, when preparing pasta or meat items in client #4's lunch. Staff F shared that today, it did not appear that client #4 was given a pureed texture with his pasta dish. In the past, the classroom has had to use their blender to further process client #4's food before offering it to him. On other occasions Staff E has called the group home and informed them that the diet texture was not consistent with pureed diet. Staff F also commented that when she attempted to thicken his (client #4's) drinks to a Nectar texture, she tried to have the beverage resemble a "slushie drink". Staff F revealed that she had not received any written instructions on his (client #4's) feeding protocol and that most of the times she used 1 to 2 scoops of thick-it powder or added water when needing to thin out the drink.

Interview on 6/5/19 with Staff J revealed that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 189	Continued From page 17	W 189		

worked in the home for five years and monitored the consistency of the drink, when thickening a liquid. She stated that she "used 2 tablespoon of thickener powder in the tea and the milk."

Interview on 6/5/19 with Staff C revealed that when she prepared the oatmeal she did not add water because " it looked like it did not need it." She added that the blender used was "very powerful and it makes everything pureed." When Staff C was asked about the blueberries in client #4's oatmeal, she responded that "they were very fine and came out in his (client #4's) stool."

Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she conducted an in-service with the majority of the group home staff on 5/30/19 to discuss dietary services. The QIDP indicated that the "in-service was prompted because the organization wanted to reduce aspiration risks and workers have been trained how to recognize aspiration." The QIDP stated "that three staff did attend the dietary service in-service, and would normally do an 1:1 training with anyone who was not there but she has not done it yet." The QIDP shared that anyone who did not attend the training still had meal preparation privileges. It was noted that Staff C did not attend the training on 5/30/19.

During a further interview with the QIDP, in relation to preparing a pureed diet for client #4, she commented that she wanted staff to prepare it to look like "baby food." The QIDP acknowledged that she did not give any specific instructions on how to achieve a pureed texture, but had provided hands on demonstration with staff and always "harped on them" (staff) to make sure his (client #4) food was right. The QIDP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 189	Continued From page 18	W 189		

commented that she could only recall getting one call from the day program about six months ago that client #4 did not receive an appropriate pureed texture for lunch. She made monthly visits to the group home and had been present for meals and had not observed any problems with the consistency of client #4's modified diet. The QIDP commented that because of client #4 having dysphasia, staff should alternate sips with bites, when feeding him.

2. Staff were not adequately trained to secure wheelchairs on the van and to utilize the lift in a safe manner.

a. During an observation at the home, on 6/4/19 at 5:50 pm, the clients were escorted by staff to the van, to prepare for transport to a community outing. Client #5 rolled his wheelchair onto the lift pad at the back of the van and locked the wheels. One staff stood inside of the van, in front of the lift while the other staff stood on the ground, operating the lift's remote. The safety strap was not placed behind client #5's wheelchair, before it was lifted onto the van.

b. During an observation at the home, on 6/5/19 at 8:40 am, client #5 rolled his wheelchair to the rear of the van to prepare for transport to day program. Staff K stood by, while client #5 locked his wheelchair. Staff K was observed pulling a strap from a pillar on the lift, across the back of client #5's wheelchair and securing the buckle of the strap to the other pillar on the left side of the lift. Staff K then operated the lift and allowed client #5 to roll himself on the van, as Staff H watched. Client #5 was seated in his wheelchair on the van when Staff H used wheelchair tie-downs to secure the chair to the van. Staff H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 189	Continued From page 19 secured two tie-downs to the front frame of the wheelchair, two tie-downs to the rear frame of the chair and a fifth tie-down to the left rear wheel of his chair. A wheelchair seatbelt was also secured around the wheelchair. c. During an observation at the home, on 6/5/19 at 8:45 am, client #4 had to be transferred from his seat on the van to a wheelchair, so that he could be taken back into the house. Staff K rolled client onto the lift while inside of the van, while Staff C stood on the ground and prepared to operate the lift. The safety strap was not placed behind client #4's wheelchair at the lift was lowered to the ground. Interview on 6/5/19 with Staff H revealed he began working at the home about a month ago and does not usually secure wheelchairs on the van. Additional interview indicated the staff had not been trained to secure wheelchairs on the van using tie-downs. Interview on 6/5/19 with Staff K revealed that he had worked at the home for five months. He shared that another staff (non-management) had trained him on operating the lift to the van but that no one had shown him how to use the safety strap while using the lift. Staff K shared that he knew to use the safety strap due to experiences using a lift at previous jobs. Staff K stated that the strap would prevent the chair from moving. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff generally watch a video on van safety for training in addition to shadowing other staff.	W 189		
W 240	INDIVIDUAL PROGRAM PLAN	W 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 240	Continued From page 20 CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #5's Individual Program Plan (IPP) included specific information to support the use of his eye glasses. This affected 1 of 3 audit clients. The finding is: Client #5's IPP did not include information regarding the use of his eye glasses. During observations throughout the survey on 6/4 - 6/5/19, client #5 did not wear eye glasses. The client was not prompted or assisted to wear eye glasses. Review on 6/5/19 of client #5's IPP dated 11/16/18 revealed he did not wear eye glasses. Additional review of client #5's record indicated he had a visual exam on 2/14/19 and a perscription for eye glasses was given. Further review of the IPP did not include any specific information regarding the use of client #5's eye glasses. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professioal (QIDP) indicated client #5 does have eye glasses and has worn them for a while. Additional interview reveakled he should be wearing them daily with staff prompting.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 21 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 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 3 audit clients (#2 and #5) received a continuous active treatment plan consisting of needed interventions and services identified in the Individual Program Plan (IPP) in the areas of medication administration and self-help skills. The findings are: 1. Client's medication administration objectives were not implemented during the administration of their medications. a. During observations of medication administration in the home on 6/5/19 at 7:45am, Staff J completed all necessary tasks without prompting or assisting client #5 to participate. During an interview with Staff J on 6/5/19, when asked if any of the clients have goals for medication administration, the staff stated, "I couldn't even tell you." Interview with Staff C indicated all of the clients have goals for medication administration and client #5 will use the manual sign for 'medication'.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 22 Review on 6/5/19 of client #5's IPP dated 11/16/18 revealed an objective to communicate using sign language during medication administration for 90 consecutive days (implemented 3/18/19). The objective noted the client should sign 'medication'. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objective was current and should have been implemented during medication administration. b. During observations of medication administration in the home on 6/5/19 at 8:10am, Staff J completed various tasks and only prompted client #2 to pour his water and take his medications. During an interview with Staff J on 6/5/19, when asked if any of the clients have goals for medication administration, the staff stated, "I couldn't even tell you." Additional interview with Staff C indicated all of the clients have goals for medication administration. Review on 6/5/19 of client #2's IPP dated 7/3/18 revealed an objective to independently participate in medication administration daily for 90 consecutive days (implemented 3/1/18). The objective included steps to wash his hands, participate in the medication administration process and identify items as part of the medication administration process. Interview on 6/5/19 with the QIDP confirmed the objective was current and should have been implemented during medication administration. Additional interview indicated client #2 can retrieve his medication bin, punch his pills and	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 23 pour his water. c. During observations of medication administration in the home on 6/5/19 from 8:25am - 8:40am, Staff J completed all necessary tasks without prompting or assisting client #4 to participate with the administration of his medications. During an interview with Staff J on 6/5/19, when asked if any of the clients have goals for medication administration, the staff stated, "I couldn't even tell you." Additional interview with Staff C indicated all of the clients have goals for medication administration. Review on 6/5/19 of client #4's IPP dated 11/21/18 revealed an objective to participate in medication administration daily for 90 consecutive days (implemented 3/21/19). Interview on 6/5/19 with the QIDP confirmed the objective was current and should have been implemented during medication administration. It should also be noted that a sheet posted on the door of the med room throughout the observatios indicated, "Incorportate clients in their med admin process to promote independence." 2. Client #5 was given full physical assistance to consume his meals. During dinner and breakfast observations in the home on 6/4 - 6/5/19 at 5:03pm and 6:55am, Staff B and Staff C provided client #5 with hand-over-hand assistance to consume his meal. This full physical assistance was provided intermittently at dinner and for the entire meal at	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 24 breakfast. Interview on 6/5/19 with Staff C revealed client #5 "hands shake" so he sometimes needs more assistance. Review on 6/5/19 of client #5's IPP dated eats independently and needs "minimal physical assistance" at meals. Interview on 6/5/19 with the QIDP indicated client #5 can feed himself and does not require full physical assistance while eating.	W 249		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Individual Program Plan (IPP) was reviewed and revised as necessary. This affected 2 of 3 audit clients (#2, #5). The findings are: 1. Client #2's IPP was not reviewed as needed. Review on 6/5/19 of client #2's IPP dated 7/3/18 revealed objectives to make a purchase 2 times per week, put away laundry for 8 consecutive weeks, follow an infection control routine daily for 90 consecutive days and to participate with the	W 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 257	Continued From page 25 administration of his medications for 90 consecutive days. The plan indicated all objectives were implemented on 3/1/18. Additional review of quarterly progress notes revealed the last progress review for the objectives was completed on 1/10/19. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she had not been able to catch up with reviewing client's objectives for progress and she could not be sure if progress had been made over the past 5 months. 2. Client #5's IPP was not reviewed as needed. Review on 6/5/19 of client #5's IPP dated 11/16/18 revealed an objective to select a movie he likes to watch for 24 consecutive weeks (implemented 3/1/18). Additional review of quarterly progress notes indicated no progress reviews for this objective. Further review of the plan identified objectives to use the restroom daily for 90 consecutive days (implemented 3/15/18), participate with his oral hygiene routine for 90 consecutive days (implemented 3/1/18), make a purchase weekly for 8 consecutive weeks (implemented 3/15/18), identify activities to participate in daily for 90 consecutive days (implemented 3/15/18) and to communicate using sign language during medication administration daily for 90 consecutive days (implemented 3/15/18). Additional review of quarterly progress notes revealed the last progress review for the objectives was completed on 1/10/19. Interview on 6/5/19 with the QIDP revealed she	W 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 257	Continued From page 26 had not been able to catch up with reviewing client's objectives for progress and she could not be sure if progress had been made over the past 5 months.	W 257		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, nursing staff failed to ensure that 1 of 3 audit clients (#4) had monthly weights recorded per physician's orders. The findings is: Client #4 did not have monthly weights recorded. Review on 6/4/19 of client #4's physician's orders signed on 3/22/19 revealed that staff were supposed to "check weight monthly before breakfast and record on back of the MAR (medication administration record)." The order had been active since 3/28/17. Review on 6/4/19 of client #4's MAR from Dec 2018 to May 2019 revealed no weights were recorded on the back of the MAR in Jan, Feb, March and April, 2019. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged that weighing client #4 had been an issue because he wouldn't be still on the scale.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 27 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: Based on observations, interviews and record review, the facility failed to ensure client #4's medications were administered in accordance with physician's orders. This affected 1 of 3 clients observed receiving medications. The finding is: Client #4's medication was not administered as prescribed. During observations of medication administration on 6/5/19 at 8:25am, Staff J retrieved one packet of Omeprazole/Bicarbonate powder oral suspension 40mg/1680mg. The staff added two tablespoons of water to the powder and an undetermined amount of Thick-it powder, stirred it and presented it to client #4. The client refused the medication. At 8:40am, Staff J added a spoonful of Ensure pudding to the medication mixture and fed it to client #4. Interview with Staff J revealed they don't usually add pudding to that particular medication but most other med techs do because they know he likes pudding. Review on 6/5/19 of client #4's physician's orders dated 3/22/19 revealed an order for Omeprazole and Bicarbonate powder oral suspension 40mg/1680mg (Zegerid 40mg packet), "empty the contents of 1 packet in a small cup containing 2 tablespoons of water. Stir well & drink once daily. Refill cup & drink. Only use water, 8am"	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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W 368	Continued From page 28 Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the medication should have been administered as written on the physician's order.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure all drugs were administered without error. This affected 3 of 3 clients (#2, #4, #5) observed receiving medications. The findings are: 1. Client #5 did not receive all ordered medications. During morning observations of medication administration in the home on 6/5/19 at 7:45am, client #5 ingested Ravicti, Tegretol, Keppra, Latulose, Fycompa, Calcium Citrate plus D3, Loratadine, Magnesium, One a Day Men's and Topiramate. Review on 6/5/19 of client #5's physician's orders for 3/1/19 - 6/30/19 (dated 3/22/19) revealed orders for "Flonase .05% nasal spray, use 2 sprays in each nostril daily, 8am" and "Klonopin .5mg, take 1 tablet by mouth twice daily, 8am, 8pm." Interview on 6/5/19 via phone with the facility's	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 369	Continued From page 29 nurse confirmed client #5's physician's orders were current. 2. Client #2 was not administered his Flonase as ordered. During morning observations of medication administration in the home on 6/5/19 at 8:10am, client #2 ingested Fisctalorpam, Gabapentin, Levothyroxine, Loratadine, Risperdal and Vascepa. The client also received one spray of Flonase nasal spray in each nostril. Review on 6/5/19 of client #2's physician's orders for 3/1/19 - 6/30/19 (dated 3/22/19) revealed an order for Flonase .05% nasal spray, "2 puffs in each nostril once daily at 8am". Interview on 6/5/19 via phone with the facility's nurse confirmed client #2's physician's orders were current. 3. Client #4's foot creams were not administered as ordered. During morning observations of medication administration in the home on 6/5/19 between 8:25am - 8:40am, client #4 ingested Vimpat, Ferrous Sulfate, Docu Liquid, Cerovite, Vitamin B-1, Vitamin D, and Omeprazole/Sodium Bicarbonate powder. The client was also administered Pataday .2% eye drops. In addition, client #2 received Hydrocortisone cream and Polysporin cream to both feet. Review on 6/5/19 of client #4's physician's orders for 3/1/19 - 6/30/19 (dated 3/22/19) indicated orders for "Lamisil 1% cream, apply to affected area twice daily for foot fungus on feet, 8am,	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

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W 369	Continued From page 30 8pm" and "Lac-hydrin 12% cream, apply to feet twice daily, 8am, 8pm". Interview on 6/5/19 via phone with the facility's nurse confirmed client #4's physician's orders were current.	W 369		
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 record review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. The finding is: Facility fire drills were not completed at varying times of the day. Review on 6/4/19 of facility fire drill reports for June 2018 - June 2019 revealed only one fire drill had been conducted on 1/10/19 at 7:30am for first shift. Other times fire drills were conducted included early morning hours of 5:06am, 1:31am, 12:07am, and 12:00am and evening hours of 4:20pm, 6:00pm, 11:50pm, 7:50pm, 7:00pm, 5:55pm, and 7:11pm. No other fire drills had been conducted during daytime hours The fire drills were not conducted at varying times and conditions for first shift. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) indicated since clients are not in the home during day time hours throughout the week, fire drills could be conducted during those hours on the weekend.	W 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 459	DIETETIC SERVICES CFR(s): 483.480 The facility must ensure that specific dietetic services requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure each client received their modified and specially-prescribed diets. (W460). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services.	W 459		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 of 3 audit clients (#4) received a modified and specially-prescribed diet as indicated. The findings are: Client #4's appropriate food and drink consistency were not followed at 3 of 3 meals. a. During observation of lunch at the day program on 6/4/19 at 12:00 pm, client #4 was being assisted with his meal by day program Staff F. Client #4 had a sectioned plate that contained a blended pasta casserole that had small chunks of green vegetables in it, smooth pureed orange	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 460	Continued From page 32	W 460		

jello and squash. In a Styrofoam cup was a red beverage. Client #4 only showed interest in drinking the red beverage. At 12:25 pm, Staff F filled client #4's cup with water and added 2 scoops of thickener, stirring the contents and offered it to client #4 who starting to drink from the cup. At 12:30 pm, client #4 was observed to cough repeatedly while finishing his drink. Staff F patted client #4 on his back, as client #4 hung his head low while seated. Client #4 was offered his food, refusing to eat the pureed squash and jello. Client #4 started to eat the pasta and was not prompted to take sips of beverage between bites. At 12:43 pm, client #4 started to cough after taking a bite of the pasta and was not offered anything to drink.

b. During observations in the home on 6/4/19 at 4:52 pm, the blender contained peas and carrots with no liquid added. Staff D turned on the blender for about 20 seconds and blended the food. There were still noticeable green and orange small chunks of the vegetables, as Staff D transferred the food on the sectioned plate. Next, Staff D scooped chicken and dumplings with broth into the blender, and processed the food for less than 10 seconds, with some visible vegetables remaining in the pureed texture. The food was presented to client #4, who would not eat anything except for the chocolate pudding. After client #4 ate the pudding, Staff A placed 4 scoops of thickener into a 4 ounce cup of tea and offered it to client #4, but he did not take any sips. Instead client #4 took a few bites of the chicken and dumplings. At 5:28 pm, Staff A put the glass of tea in front of client #4 but did not verbally prompt him to take sips. Client #4 reached for the glass of tea and took several sips, before he was led out of the room for a wardrobe change.

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	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 460	Continued From page 33 c. During observations in the home on 6/5/19 at 6:20 am, Staff C had just finished using the blender to puree the oatmeal for client #4's breakfast. At 6:28 am, client #4 sat next to Staff J who has already scooped an undetermined amount of thickener in a 6 ounce glass of tea and was stirring the contents. Client #4 had a section plate with smooth pureed scrambled eggs and french toast sticks and lumpy oatmeal with pieces of blueberries. Client #4 started to feed himself, eating the oatmeal. At 6:38 am, Staff J asked Staff K if there were blueberries in the oatmeal and Staff K responded that it contained blueberries and bananas. Client #4 did some infrequent coughing as he continued to eat his meal and Staff J patted him on his back. Client #4 did not take any sips of fluids during his meal and was not prompted by staff. Client #4 went to sit down in a chair, after eating breakfast. Staff J brought the tea to him and also prepared a 4 ounce cup of milk that had 2 tablespoon of thickener placed in it. Client #4 drank the tea, then drank his milk. The container of unflavored thickener was examined. It stated to reach nectar consistency, 4-5 tablespoon should be added to the beverage and then allow the beverage to sit for 30 seconds. The instructions did not specify if adjustments should be made based on the amount of fluid ounces in the glass. Review on 6/4/19 of the Annual Nursing Summary dated on 2/21/19 revealed that client #4 was on a pureed diet with thicken liquids, due to a choking incident in March 2014. Client #4 was noted by the nurse to be an aspiration risk. Additional review of the physician's orders signed 3/22/19 revealed that client #4 was on a pureed diet with nectar consistency and should take	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

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PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

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W 460	Continued From page 34 small bites with sips. Review on 6/5/19 of client #4's Speech Language Pathology Initial Evaluation dated 2/19/19- revealed that client #4 was diagnosed with oropharyngeal dysphasia (swallowing disorder) and that clinical rick factors for aspiration that were present during the assessment, was that he produced a wet/aphonic vocal quality (inadequate voice support to produce intelligible speech) after swallowing. Factors compounding risk of aspiration was client #4's cognitive deficits and dependence on feeding. Observations included that client #4 had prolonged oral holding of pureed intake. He had questionable wet vocal quality but otherwise had no signs or symptoms of aspiration. Client #4 had 7 more pureed trials by 2/21/19 and was discontinued from speech language pathology treatment after demonstrating no overt signs or symptoms of aspiration. It was recommended that client #4 should alternate solids and liquids, and take small bites and sips. An additional review on 6/4/19 of the Dietary Inservice dated 4/7/18, which hung on the facility's kitchen wall, revealed that when preparing a modified diet of pureed consistency, food is smooth, moist and lump free; may have a grainy texture; thickened liquids at nectar thick, fluid runs freely off the spoon but leaves a mild coating on the spoon. When using a thickening powder or thickening agent, staff were to follow the instructions on container. It further added that signs and symptoms of choking, include struggling to breathe (gasping), coughing, gagging, and bluish lips or skin. Interview on 6/4/19 with day program Staff F	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 460	Continued From page 35	W 460		

revealed that the group home did not send a consistent pureed texture, when preparing pasta or meat items in client #4's lunch. Staff F shared that today, it did not appear that client #4 was given a pureed texture with his pasta dish. In the past, the classroom has had to use their blender to further process client #4's food before offering it to him. On other occasions Staff E has called the group home and informed them that the diet texture was not consistent with pureed diet. Staff F also commented that when she attempted to thicken his (client #4's) drinks to a Nectar texture, she tried to have the beverage resemble a "slushie drink". Staff F revealed that she had not received any written instructions on his (client #4's) feeding protocol and that most of the times she used 1 to 2 scoops of thick-it powder or added water when needing to thin out the drink.

Interview on 6/5/19 with Staff J revealed that she worked in the home for five years and monitored the consistency of the drink, when thickening a liquid. She stated that she "used 2 tablespoon of thickener powder in the tea and the milk."

Interview on 6/5/19 with Staff C revealed that when she prepared the oatmeal she did not add water because " it looked like it did not need it." She added that the blender used was "very powerful and it makes everything pureed." When Staff C was asked about the blueberries in client #4's oatmeal, she responded that "they were very fine and came out in his (client #4's) stool."

Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she conducted an in-service with the majority of the group home staff on 5/30/19 to discuss dietary services. The QIDP indicated that the "in-service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 460	Continued From page 36 was prompted because the organization wanted to reduce aspiration risks and workers have been trained how to recognize aspiration." The QIDP stated "that three staff did attend the dietary service in-service, and would normally do an 1:1 training with anyone who was not there but she has not done it yet." The QIDP shared that anyone who did not attend the training still had meal preparation privileges. It was noted that Staff C did not attend the training on 5/30/19. During a further interview with the QIDP, in relation to preparing a pureed diet for client #4, she commented that she wanted staff to prepare it to look like "baby food." The QIDP acknowledged that she did not give any specific instructions on how to achieve a pureed texture, but had provided hands on demonstration with staff and always "harped on them" (staff) to make sure his (client #4) food was right. The QIDP commented that she could only recall getting one call from the day program about six months ago that client #4 did not receive an appropriate pureed texture for lunch. She made monthly visits to the group home and had been present for meals and had not observed any problems with the consistency of client #4's modified diet. The QIDP commented that because of client #4 having dysphasia, staff should alternate sips with bites, when feeding him.	W 460		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and	W 475		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 475	Continued From page 37 interview, the facility failed to ensure client #4's adaptive dining utensils were utilized at meals. This affected 1 of 3 audit clients. The finding is: 3. Client #4 was not given the proper adaptive utensils at meals. During a dinner observation on 6/4/19 at 5:00 pm, client #4 was using a regular spoon to eat chocolate pudding from a sectioned plate. An additional breakfast observation on 6/5/19 at 6:45 am, revealed client #4 was using a regular spoon to feed himself modified texture oatmeal, scrambled eggs and french toast sticks. Review on 6/4/19 of client #4's Nutritional Evaluation dated on 8/16/18, revealed that adaptive equipment needed at his meals included a section plate with built up utensils. In addition, the IPP dated on 11/21/18 revealed client #4 required staff's assistance with eating to use all utensils correctly. Interview on 6/5/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed on 5/30/19 she conducted an in-service with the majority of the staff on dietary services. Part of it's content focused on making sure that clients had adaptive equipment, as ordered, provided to them.	W 475		