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

PRINTED: 06/14/2019
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
	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 03 2	Primary/A1temate Means for Communication CFR(s): 483.475(c)(3) [(c) The [faci1ity] must deve1op and maintain an emergency preparedness communication p1an that comp1ies with Federa1, State and 1oca1 1aws and must be reviewed and updated at 1east annua11y.] The communication p1an must inc1ude a11 of the fo11owing: (3) Primary and a1temate means for communicating with the fo11owing: (i) [Faci1ity] staff. (ii) Federa1, State, triba1, regiona1, and 1oca1 emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and a1temate means for communicating with the ICF/IID's staff, Federa1, State, triba1, regiona1, and 1oca1 emergency management agencies. This STANDARD is not met as evidenced by: Based on interview and document review, the faci1ity fai1ed to ensure the Emergency Preparedness (EP) p1an inc1uded information regarding an a1temative means of communicating with faci1ity staff, federa1, state, regiona1 and 1oca1 emergency management agencies. The finding is: Information to address an a1temative means of communication to be used in the event of an emergency was not inc1uded in the EP. Review on 6/5/19 of the faci1ity's EP p1an (updated 4/3/18) did not inc1ude information regarding an a1temative means of communication in the event of a power fai1ure. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed the	E 032	The facility will ensure that the Emergency Preparedness Plan (EPP) is updated to include documentation of an alternative means of communication in the event of an actual emergency. The QP will update the EPP to include the use of a cell phone in the home and staff cell phones as alternatives to the land line phone system. The QP will provide in-service training on the updated EPP to all applicable staff. The ICF Director and/or QA will monitor the EPP monthly to ensure continued compliance. DHSR - Mental Health JUL 01 2019 Lic. & Cert. Section	8/2/19 8/2/19

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

Laura Jacobs, COO/Administrator — 6/25/19

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 disc1osab1e 90 days fo11owing the date of survey whether or not a p1an of correction is provided. For nursing homes, the above findings and p1ans of correction are disc1osab1e 14 days fo11owing the date these documents are made avai1ab1e to the faci1ity. If deficiencies are cited, an approved p1an 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
	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 03 2	Continued From page 1	E 032		
	home has a ce11 phone which cou1d be used in emergencies and staff have permission to uti1ize their persona1 ce11 phones at that time. The QIDP acknow1edged this information shou1d be inc1uded in the faci1ity's EP p1an to address a1ternative means of communication. At the time of this interview, the QIDP indicated the faci1ity's ce11 phone cou1d not be 1ocated.			
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [faci1ity, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dia1ysis faci1ities] must do a11 of the fo11owing: (i) Initia1 training in emergency preparedness po1icies and procedures to a11 new and existing staff, individua1s providing services under arrangement, and vo1unteers, consistent with their expected ro1e. (ii) Provide emergency preparedness training at 1east annua11y. (iii) Maintain documentation of the training. (iv) Demonstrate staff know1edge of emergency procedures. *[For Hospita1s at §48 2.15(d) and RHCs/FQHCs at §491.1 2:] (1) Training program. The [Hospita1 or RHC/FQHC] must do a11 of the fo11owing: (i) Initia1 training in emergency preparedness po1icies and procedures to a11 new and existing staff, individua1s providing on-site services under arrangement, and vo1unteers, consistent with their expected ro1es. (ii) Provide emergency preparedness training at 1east annua11y. (iii) Maintain documentation of the training. (iv) Demonstrate staff know1edge of emergency procedures.	E 037		

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

NAME OF PROVIDER OR SUPPLIER

PINE RIDGE GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 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 037	Continued From page 2 *[For Hospices at §418.113(d):] (1) Training. The hospice must do a11 of the fo11owing: (i) Initia1 training in emergency preparedness po1icies and procedures to a11 new and existing hospice emp1oyees, and individua1s providing services under arrangement, consistent with their expected ro1es. (ii) Demonstrate staff know1edge of emergency procedures. (iii) Provide emergency preparedness training at 1east annua11y. (iv) Periodica11y review and rehearse its emergency preparedness p1an with hospice emp1oyees (inc1uding nonemp1oyee staff), with specia1 emphasis p1aced on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do a11 of the fo11owing: (i) Initia1 training in emergency preparedness po1icies and procedures to a11 new and existing staff, individua1s providing services under arrangement, and vo1unteers, consistent with their expected ro1es. (ii) After initia1 training, provide emergency preparedness training at 1east annua11y. (iii) Demonstrate staff know1edge of emergency procedures. (iv) Maintain documentation of a11 emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do a11 of the fo11owing: (i) Initia1 training in emergency preparedness po1icies and procedures to a11 new and existing staff, individua1s providing on-site services under	E 037		

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

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 037	Continued From page 3 arrangement, contractors, participants, and vo1unteers, consistent with their expected ro1es. (ii) Provide emergency preparedness training at 1east annua11y. (iii) Demonstrate staff know1edge of emergency procedures, inc1uding informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of a11 training. *[For CORFs at §485.68(d):](1) Training. The CORF must do a11 of the fo11owing: (i) Provide initia1 training in emergency preparedness po1icies and procedures to a11 new and existing staff, individua1s providing services under arrangement, and vo1unteers, consistent with their expected ro1es. (ii) Provide emergency preparedness training at 1east annua11y. (iii) Maintain documentation of the training. (iv) Demonstrate staff know1edge of emergency procedures. A11 new personne1 must be oriented and assigned specific responsibi1ities regarding the CORF's emergency p1an within 2 weeks of their first workday. The training program must inc1ude instruction in the 1ocation and use of a1arm systems and signa1s and firefighting equipment. *[For CAHs at §485.6 25(d):] (1) Training program. The CAH must do a11 of the fo11owing: (i) Initia1 training in emergency preparedness po1icies and procedures, inc1uding prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personne1, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to a11 new and existing staff,	E 037		

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

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 037	Continued From page 4 individua1s providing services under arrangement, and vo1unteers, consistent with their expected ro1es. (ii) Provide emergency preparedness training at 1east annua11y. (iii) Maintain documentation of the training. (iv) Demonstrate staff know1edge of emergency procedures. *[For CMHCs at §485.9 20(d):] (1) Training. The CMHC must provide initia1 training in emergency preparedness po1icies and procedures to a11 new and existing staff, individua1s providing services under arrangement, and vo1unteers, consistent with their expected ro1es, and maintain documentation of the training. The CMHC must demonstrate staff know1edge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at 1east annua11y. This STANDARD is not met as evidenced by: Based on record review and interviews, the faci1ity fai1ed to ensure direct care staff were trained on the faci1ity's Emergency Preparedness (EP) p1an. The finding is: Staff had not been trained on the faci1ity's EP p1an. Review on 6/5/19 of the faci1ity's EP p1an (updated 4/3/18) did not inc1ude any information regarding training of staff. During an interview on 6/5/19, the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed staff had not been retrained on the faci1ity's EP p1an since the p1an was initiated.	E 037	The facility will ensure that all staff in the home receive initial training on the Emergency Preparedness Plan (EPP) and any updates thereafter to address their competencies in its implementation. The QP will provide initial and update staff training on the EPP to increase staff knowledge and competencies in the event of an actual emergency. The ICF Director and/or QA will monitor staff training records on the EPP on a quarterly basis to ensure continued compliance.	8/2/19 8/2/19

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

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 039	Continued From page 5	E 039		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [faci1ity, except for LTC faci1ities, RNHCls and OPOs] must conduct exercises to test the emergency p1an at 1east annua11y. The [faci1ity, except for RNHCls and OPOs] must do a11 of the fo11owing: *[For LTC Faci1ities at §483.73(d):] (2) Testing. The LTC faci1ity must conduct exercises to test the emergency p1an at 1east annua11y, inc1uding unannounced staff dri11s using the emergency procedures. The LTC faci1ity must do a11 of the fo11owing:] (i) Participate in a fu11-sca1e exercise that is community-based or when a community-based exercise is not accessib1e, an individua1, faci1ity-based. If the [faci1ity] experiences an actua1 natura1 or man-made emergency that requires activation of the emergency p1an, the [faci1ity] is exempt from engaging in a community-based or individua1, faci1ity-based fu11-sca1e exercise for 1 year fo11owing the onset of the actua1 event. (ii) Conduct an additiona1 exercise that may inc1ude, but is not 1imited to the fo11owing: (A) A second fu11-sca1e exercise that is community-based or individua1, faci1ity-based. (B) A tab1etop exercise that inc1udes a group discussion 1ed by a faci1itator, using a narrated, c1inica11y-re1evant emergency scenario, and a set of prob1em statements, directed messages, or prepared questions designed to cha11enge an emergency p1an. (iii) Ana1yze the [faci1ity's] response to and maintain documentation of a11 dri11s, tab1etop	E 039		

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,
PINE RIDGE GROUP HOME	ZIP CODE 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 039	Continued From page 6 exercises, and emergency events, and revise the [faci1ity's] emergency p1an, 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 p1an. The [RNHCI and OPO] must do the fo11owing: (i) Conduct a paper-based, tab1etop exercise at 1east annua11y. A tab1etop exercise is a group discussion 1ed by a faci1itator, using a narrated, c1inica11y re1evant emergency scenario, and a set of prob1em statements, directed messages, or prepared questions designed to cha11enge an emergency p1an. (ii) Ana1yze the [RNHCI's and OPO's] response to and maintain documentation of a11 tab1etop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency p1an, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the faci1ity fai1ed to ensure a faci1ity/community-based or tab1etop exercise was conducted to test their emergency p1an. The finding is: The faci1ity's Emergency Preparedness (EP) p1an did not inc1ude comp1etion of faci1ity/community-based exercise or tab1etop exercise. Review on 6/5/19 of the faci1ity's EP p1an (updated 4/3/18) did not inc1ude a fu11-sca1e community-based or individua1 faci1ity-based exercise or a tab1etop exercise to test their emergency p1an. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) confirmed the	E 039	The facility will ensure that the Emergency Preparedness Plan (EPP) is activated in practice to include a facility-based exercise to test utilization towards safe evacuation, deployment and access to appropriate resources in the event of an emergency. The QP will facilitate a practice exercise of an actual event to include the activation of the EPP to include but not limited to accessing community resources and contacts. The QP will document the results of the activated EPP and note areas of follow-up for further improvement. The QP will provide staff feedback on the activation of the EPP and document accordingly. The ICF Director and/or QA will monitor the EPP quarterly to ensure continued compliance.	8/2/19 8/2/19

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 039	Continued From page 7 faci1ity has not conducted a fu11-sca1e faci1ity/community-based exercise or a tab1etop exercise to test the effectiveness of their current emergency p1an.	E 039		
W 1 20	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The faci1ity must assure that outside services meet the needs of each c1ient. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the faci1ity fai1ed to ensure outside services met the needs of 2 of 3 audit c1ients (#4, #5). The findings are: 1. At the day program, c1ient #4 was served food and drinks which did not meet his appropriate diet texture and staff did not fo11ow his feeding guide1ines. During observations of 1unch at the day program on 6/4/19 at 1 2:00 pm, c1ient #4 was being assisted with his mea1 by day program Staff F. C1ient #4 had a sectioned p1ate that contained a b1ended pasta cassero1e that had sma11 chunks of green vegetab1es in it, smooth pureed orange je11o and squash. In a Styrofoam cup was a red beverage. C1ient #4 on1y showed interest in drinking the red beverage. At 1 2: 25 pm, Staff F fi11ed c1ient #4's cup with water and added 2 scoops of thickener, stirring the contents and offered it to c1ient #4 who starting to drink from the cup. At 1 2:30 pm, c1ient #4 was observed to cough repeated1y whi1e finishing his drink. Staff F patted c1ient #4 on his back, as c1ient #4 hung his	W 1 20	The facility will ensure that outside services meet client needs to include serving food at appropriate diet texture and following feeding guidelines in accordance with the Individual Support Plans. For Client #4 the staff at the day program will be in-service on his diet of pureed food and thicken liquids. The QIDP will provide in-service training to day program staff on the presentation of pureed foods and thicken liquids. The day program staff will check the lunch upon client #4 arrival and will contact the QIDP immediately if the food consistency is not pureed and the liquids is not thickened in accordance with the diet. The QIDP and/or Home Manager will monitor meals at the day program weekly to ensure continued compliance.	8/2/19 8/2/19

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

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 1 20	Continued From page 8 head 1ow whi1e seated. C1ient #4 was offered his food, refusing to eat the pureed squash and je11o. C1ient #4 started to eat the pasta and was not prompted to take sips of beverage between bites. At 1 2:43 pm, c1ient #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 Annua1 Nursing Summary dated on 2/21/19 revea1ed that c1ient #4 was on a pureed diet with thicken 1iquids, due to a choking incident in March 2014. C1ient #4 was noted by the nurse to be an aspiration risk. Additiona1 review of the physician's orders signed 3/22/19 revea1ed that c1ient #4 was on a pureed diet with nectar consistency and shou1d take sma11 bites with sips. Interview on 6/4/19 with Staff F revea1ed that the group home did not send a consistent pureed texture, when preparing pasta or meat items in c1ient #4's 1unch. Staff F shared that today, it did not appear that c1ient #4 was given a pureed texture with his pasta dish. In the past, the c1assroom has had to use their b1ender to further process c1ient #4's food before offering it to him. On other occasions Staff E has ca11ed the group home and informed them that the diet texture was not consistent with pureed diet. Staff F a1so commented that when she attempted to thicken c1ient #4's drinks to a nectar texture, she tried to have the beverage resemb1e a "s1ushie drink". Staff F stated that she had not received any written instructions on his (c1ient #4's) feeding protoco1 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 Qua1ity Inte11ectua1	W 1 20		

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 1 20	Continued From page 9 Disabi1ities Professiona1 (QIDP) revea1ed that she cou1d on1y reca11 getting one ca11 from the day program about six months ago that c1ient #4 did not receive an appropriate pureed texture for 1unch. 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 shou1d a1ternate sips with bites. 2. C1ient #5 was fed during 1unch at the day program. During 1unch observations at the day program on 6/4/19 at 1 2:05pm, c1ient #5 was initia11y noted to feed himse1f independent1y using a bui1t-up hand1e spoon. At 1 2: 25pm, Staff E approached the c1ient and asked, "Do you want me to do it for you?" Staff E then retrieved the adaptive spoon and began feeding c1ient #5 the remainder of his 1unch mea1. Review on 6/4/19 of c1ient #5's IPP dated 11/16/18 revea1ed he eats with minima1 physica1 assistance. Interview on 6/5/19 with the QIDP indicated c1ient #5 can feed himse1f with minima1 assistance needed and he shou1d not have been fed by staff. 3. C1ient #5's adaptive cup was not uti1ized at the day program. During 1unch observations at the day program on 6/4/19 at 1 2:05pm, c1ient #5 drank from a Styrofoam cup and a sma11 drink jug. Whi1e using the Styrofoam cup, the c1ient bit a chunk out of the rim of the cup. Review on 6/4/19 of c1ient #5's Individua1	W 1 20	For Client #5 the staff at the day program will be in-service on the IPP relative to feeding skills. The QIDP will provide in-service training to day program staff on allowing the client to feed self with minimal assistance. Staff will be advised not to feed the client, only provide minimal support per the IPP. The QIDP and/or Home Manager will monitor meals at the day program weekly to ensure continued compliance. For Client #5 the staff at the day program will be in-service on the use of adaptive cup per IPP. The QIDP will provide in-service training on use of adaptive cup. The home manager will ensure that the adaptive cup is available to day program staff. The QIDP will be contacted if the adaptive cup is not available upon client arrival to the day program daily. The QIDP and/or Home Manager will monitor meals at the day program weekly to ensure continued compliance.	8/2/19 8/2/19

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

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 1 20	Continued From page 10 Program P1an (IPP) dated 11/16/18 revea1ed, under adaptive eating equipment, the c1ient uti1izes a "weighted cup". Interview on 6/5/19 with the QIDP confirmed c1ient #5 shou1d use an adaptive cup at mea1s and his dining equipment shou1d be avai1ab1e at the day program. 4. C1ient #5 wore a c1othing protector during 1unch at the day program. During 1unch observations at the day program on 6/4/19 at 1 2:05pm, c1ient #5 wore a c1othing protector secured around his neck as he consumed his mea1. Review on 6/4/19 of c1ient #5's IPP dated 11/16/18 did not indicate the c1ient required a c1othing protector at mea1s. Interview on 6/5/19 with the QIDP revea1ed c1ient #5 does not wear a c1othing protector at mea1s in the home and shou1d not have needed one at the day program.	W 1 20	For Client #5 the staff at the day program will no longer use a clothing protector during meals unless specified in the IPP. The QIDP will provide in-service training to day program staff on not using a clothes protector and prompting the use of napkins to wipe away food or verbal prompts if needed for potential food spillage issues. The QIDP and/or Home Manager will monitor meals at the day program weekly to ensure continued compliance.	8/2/19
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.4 20(a)(1 2) The faci1ity must ensure the rights of a11 c1ients. Therefore, the faci1ity must ensure that c1ients have the right to retain and use appropriate persona1 possessions and c1othing. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the faci1ity fai1ed to ensure 2 of 3 audit c1ients (#2, #4) had the right to c1othing 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

(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 137	**Continued From page 11** **appropriate size and fit. The finding is:** **1. C1ient #2's jeans did not fit him proper1y.** **During observations throughout the survey at the day program and in the home on 6/4/19, c1ient #2 wore jeans which were 1oose around his waist and baggy. Each time the c1ient stood from a seated position, his pants s1ipped down exposing his underwear and buttocks. As the c1ient wa1ked to various areas of the day program and home, he consistent1y and repeated1y he1d up his pants with one hand to prevent them from fa11ing down. The c1ient was observed to perform various tasks 1ike setting the tab1e and c1earing his dishes whi1e ho1ding up his jeans with one hand. A1though c1ient #2 wore a be1t, his jeans continued to s1ip down. C1ient #2 was not prompted or assisted to change his jeans and 1eft the home at 5:58pm on a community outing.** **Review on 6/5/19 of c1ient #2's Individua1 Program P1an (IPP) dated 7/3/18 revea1ed he requires prompts to "fu11y dress". The p1an a1so identified a need with putting on his c1othing.** **Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed his mother usua11y purchases c1ient #2's c1othing for him and without him trying them on.** **2. C1ient #4 was dressed in 1ose fitting pants that fe11 down.** **During observations at the day program and home on 6/4/19, c1ient #4 wore two different pairs of shorts that were 1ose fitting and fe11 to his ank1es. Initia11y at the day program, c1ient #4 wore a size 3 2 khaki shorts without a be1t. During the**	W 137	The facility will ensure that all cleints have clothing in appropriate quantity and quality in accordance with their rights and dignity. The home manager will conduct an inventory of all cleints clothing to determine damaged, ill fitting, loose clothing or issues with the appropriateness of size and condition. The home manger will generate a list of clothing needs for the QIDP to follow-up on. The QIDP will take the necessary steps to obtain suitable clothing for all clients. Client #2 and #4 will receive clothing that fit them appropriately. Staff will receive in-service training on appropriateness of dress and to direct clients to change if clothing does not fit properly or is not in good condition. The QIDP and/or home manager will conduct weekly observations in home and day program to ensure continued compliance.	8/2/19 8/2/19

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 137	Continued From page 1 2 mea1, c1ient #4 stood up from this chair, which caused his shorts to fa11 to the f1oor, revea1ing an incontinence brief. There were nine c1ients and three staff present in the c1assroom when this happened. Staff F pu11ed up c1ient #4's shorts, then took the narrow c1oth gait be1t from around his waist and p1aced it through the be1t 1oops on his shorts. The gait be1t was rep1aced around c1ient #4's waist. Next, when c1ient #4 stood to be transferred to the whee1chair, he was ab1e to pu11 his shorts down, exposing his brief. When Staff G wa1ked c1ient #4 to the tab1e, his shorts started to s1ide down his thighs, creating some sagging with the incontinence brief. An additiona1 observation at the home at 5:45 pm, revea1ed c1ient #4 was now wearing a ny1on ath1etic short, with drawstring waist band, as he sat at the dinner tab1e. When c1ient #4 stood, he wou1d pu11 down his shorts, which prompted Staff A to pu11 the shorts back up and ho1d onto c1ient #4's waistband. After c1ient #4 finished his mea1, Staff C took him back to his room and changed his c1othes to ny1on ath1etic shorts, which fit better. Review on 6/4/19 of c1ient #4's IPP dated 11/21/18 revea1ed that he needed minimum assistance when putting c1othes on. Interview on 6/5/19 with the QIDP revea1ed that c1ients c1othes wou1d be examined and/or rep1aced for best fit.	W 137		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The faci1ity must provide each emp1oyee with initia1 and continuing training that enab1es 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

(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 13 emp1oyee to perform his or her duties effective1y, efficient1y, and competent1y. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the faci1ity fai1ed to ensure a11 staff were sufficient1y trained to imp1ement c1ient #4's appropriate food/drink consistency, feeding guide1ines and to safe1y 1oad/secure whee1chairs on the van. This affected 2 of 3 audit c1ients (#4, #5). The findings are: 1. C1ient #4's appropriate food and drink consistency or his feeding guide1ines were not fo11owed at 3 of 3 mea1s. a. During observation of 1unch at the day program on 6/4/19 at 1 2:00 pm, c1ient #4 was being assisted with his mea1 by day program Staff F. C1ient #4 had a sectioned p1ate that contained a b1ended pasta cassero1e that had sma11 chunks of green vegetab1es in it, smooth pureed orange je11o and squash. At 1 2: 25 pm, Staff F fi11ed c1ient #4's cup with water and added 2 scoops of thickener, stirring the contents and offered it to c1ient #4 who starting to drink from the cup. At 1 2:30 pm, c1ient #4 was observed to cough repeated1y whi1e finishing his drink. Staff F patted c1ient #4 on his back, as c1ient #4 hung his head 1ow whi1e seated. C1ient #4 started to eat the pasta and was not prompted to take sips of beverage between bites. At 1 2:43 pm, c1ient #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 4:5 2 pm, the b1ender contained peas and carrots with no 1iquid added. Staff D turned on the	W 189	The facility will ensure that staff receive training and demonstrate competencies to implement appropriate food and liquid consistencies per diet orders; follow feeding guidelines and to safely load and secure wheelchairs on vans per Individual Support Plans and CI procedures. For Client #4 the staff will be in-service on his diet of pureed food and thicken liquids. The Nutritionist and the QIDP will provide in-service training to staff on the presentation of pureed foods and thicken liquids. In addition, staff will receive training on the feeding guidelines for Client #4 to prevent potential aspiration given diagnosis of dysphasia. Nutritionist will in-service staff on all client diets as well. The QIDP and/or Home Manager will monitor meals in the home weekly to ensure continued compliance.	8/2/19 8/2/19

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 b1ender for about 20 seconds and b1ended the food. There were sti11 noticeab1e green and orange sma11 chunks of the vegetab1es, as Staff D transferred the food on the sectioned p1ate. Next, Staff D scooped chicken and dump1ings with broth into the b1ender, and processed the food for 1ess than 10 seconds, with some visib1e vegetab1es remaining in the pureed texture. The food was presented to c1ient #4, who wou1d not eat anything except for the choco1ate pudding. After c1ient #4 ate the pudding, Staff A p1aced 4 scoops of thickener into a 4 ounce cup of tea and offered it to c1ient #4, but he did not take any sips. Instead c1ient #4 took a few bites of the chicken and dump1ings. At 5: 28 pm, Staff A put the g1ass of tea in front of c1ient #4 but did not verba11y prompt him to take sips. C1ient #4 reached for the g1ass of tea and took severa1 sips, before he was 1ed 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 b1ender to puree the oatmea1 for c1ient #4's breakfast. At 6: 28 am, c1ient #4 sat next to Staff J who has a1ready scooped an undetermined amount of thickener in a 6 ounce g1ass of tea and was stirring the contents. C1ient #4 had a section p1ate with smooth pureed scramb1ed eggs and french toast sticks and 1umpy oatmea1 with pieces of b1ueberries. C1ient #4 started to feed himse1f, eating the oatmea1. At 6:38 am, Staff J asked Staff K if there were b1ueberries in the oatmea1 and Staff K responded that it contained b1ueberries and bananas. C1ient #4 did some infrequent coughing as he continued to eat his mea1 and Staff J patted him on his back. C1ient #4 did not take any sips of f1uids during his mea1 and was not prompted by staff. C1ient #4 went to sit down in a chair, after eating breakfast. Staff J	W 189		

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

NAME OF PROVIDER OR SUPPLIER
PINE RIDGE GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 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 brought the tea to him and a1so prepared a 4 ounce cup of mi1k that had 2 tab1espoon of thickener p1aced in it. C1ient #4 drank the tea, then drank his mi1k. The container of unf1avored thickener was examined. It stated to reach nectar consistency, 4-5 tab1espoon shou1d be added to the beverage and then a11ow the beverage to sit for 30 seconds. The instructions did not specify if adjustments shou1d be made based on the amount of f1uid ounces in the g1ass. Review on 6/4/19 of the Annua1 Nursing Summary dated on 2/21/19 revea1ed that c1ient #4 was on a pureed diet with thicken 1iquids, due to a choking incident in March 2014. C1ient #4 was noted by the nurse to be an aspiration risk. Additiona1 review of the physician's orders signed 3/22/19 revea1ed that c1ient #4 was on a pureed diet with nectar consistency and shou1d take sma11 bites with sips. Review on 6/5/19 of c1ient #4's Speech Language Patho1ogy Initia1 Eva1uation dated 2/19/19- revea1ed that c1ient #4 was diagnosed with oropharyngea1 dysphasia (swa11owing disorder) and that c1inica1 rick factors for aspiration that were present during the assessment, was that he produced a wet/aphonic voca1 qua1ity (inadequate voice support to produce inte11igib1e speech) after swa11owing. Factors compounding risk of aspiration was c1ient #4's cognitive deficits and dependence on feeding. Observations inc1uded that c1ient #4 had pro1onged ora1 ho1ding of pureed intake. He had questionab1e wet voca1 qua1ity but otherwise had no signs or symptoms of aspiration. C1ient #4 had 7 more pureed tria1s by 2/21/19 and was discontinued from speech 1anguage patho1ogy treatment after demonstrating no overt signs or symptoms of	W 189		

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

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 aspiration. It was recommended that c1ient #4 shou1d a1ternate so1ids and 1iquids, and take sma11 bites and sips. An additiona1 review on 6/4/19 of the Dietary Inservice dated 4/7/18, which hung on the faci1ity's kitchen wa11, revea1ed that when preparing a modified diet of pureed consistency, food is smooth, moist and 1ump free; may have a grainy texture; thickened 1iquids at nectar thick, f1uid runs free1y off the spoon but 1eaves a mi1d coating on the spoon. When using a thickening powder or thickening agent, staff were to fo11ow the instructions on container. It further added that signs and symptoms of choking, inc1ude strugg1ing to breathe (gasping), coughing, gagging, and b1uish 1ips or skin. Interview on 6/4/19 with day program Staff F revea1ed that the group home did not send a consistent pureed texture, when preparing pasta or meat items in c1ient #4's 1unch. Staff F shared that today, it did not appear that c1ient #4 was given a pureed texture with his pasta dish. In the past, the c1assroom has had to use their b1ender to further process c1ient #4's food before offering it to him. On other occasions Staff E has ca11ed the group home and informed them that the diet texture was not consistent with pureed diet. Staff F a1so commented that when she attempted to thicken his (c1ient #4's) drinks to a Nectar texture, she tried to have the beverage resemb1e a "s1ushie drink". Staff F revea1ed that she had not received any written instructions on his (c1ient #4's) feeding protoco1 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 revea1ed that she	W 189		

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

NAME OF PROVIDER OR SUPPLIER
PINE RIDGE GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 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 worked in the home for five years and monitored the consistency of the drink, when thickening a 1iquid. She stated that she "used 2 tab1espoon of thickener powder in the tea and the mi1k." Interview on 6/5/19 with Staff C revea1ed that when she prepared the oatmea1 she did not add water because " it 1ooked 1ike it did not need it." She added that the b1ender used was "very powerfu1 and it makes everything pureed." When Staff C was asked about the b1ueberries in c1ient #4's oatmea1, she responded that "they were very fine and came out in his (c1ient #4's) stoo1." Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed 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 wou1d norma11y 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 sti11 had mea1 preparation privi1eges. It was noted that Staff C did not attend the training on 5/30/19. During a further interview with the QIDP, in re1ation to preparing a pureed diet for c1ient #4, she commented that she wanted staff to prepare it to 1ook 1ike "baby food." The QIDP acknow1edged that she did not give any specific instructions on how to achieve a pureed texture, but had provided hands on demonstration with staff and a1ways "harped on them" (staff) to make sure his (c1ient #4) food was right. The QIDP	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

(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 commented that she cou1d on1y reca11 getting one ca11 from the day program about six months ago that c1ient #4 did not receive an appropriate pureed texture for 1unch. She made month1y visits to the group home and had been present for mea1s and had not observed any prob1ems with the consistency of c1ient #4's modified diet. The QIDP commented that because of c1ient #4 having dysphasia, staff shou1d a1ternate sips with bites, when feeding him. 2. Staff were not adequate1y trained to secure whee1chairs on the van and to uti1ize the 1ift in a safe manner. a. During an observation at the home, on 6/4/19 at 5:50 pm, the c1ients were escorted by staff to the van, to prepare for transport to a community outing. C1ient #5 ro11ed his whee1chair onto the 1ift pad at the back of the van and 1ocked the whee1s. One staff stood inside of the van, in front of the 1ift whi1e the other staff stood on the ground, operating the 1ift's remote. The safety strap was not p1aced behind c1ient #5's whee1chair, before it was 1ifted onto the van. b. During an observation at the home, on 6/5/19 at 8:40 am, c1ient #5 ro11ed his whee1chair to the rear of the van to prepare for transport to day program. Staff K stood by, whi1e c1ient #5 1ocked his whee1chair. Staff K was observed pu11ing a strap from a pi11ar on the 1ift, across the back of c1ient #5's whee1chair and securing the buck1e of the strap to the other pi11ar on the 1eft side of the 1ift. Staff K then operated the 1ift and a11owed c1ient #5 to ro11 himse1f on the van, as Staff H watched. C1ient #5 was seated in his whee1chair on the van when Staff H used whee1chair tie-downs to secure the chair to the van. Staff H	W 189	The facility will ensure that staff receive training and demonstrate competencies to operate the lift, safely load, unload, secure straps and tie downs in wheelchairs for clients on the van per Individual Support Plans and CI procedures. For Client #5 the home manager and QIDP will in-service all staff on loading, unloading and securing the safety straps during operation of the van lift. For Client #4 the staff will receive in-service on tie downs, use of straps to ensure safety while loading, unloading and during transport. The QIDP and home manager will provide in-service training to staff. The QIDP and/or Home Manager will monitor loading/unloading of the van on a weekly basis to ensure continued compliance.	8/2/19 8/2/19

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

NAME OF PROVIDER OR SUPPLIER

PINE RIDGE GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 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 whee1chair, two tie-downs to the rear frame of the chair and a fifth tie-down to the 1eft rear whee1 of his chair. A whee1chair seatbe1t was a1so secured around the whee1chair. c. During an observation at the home, on 6/5/19 at 8:45 am, c1ient #4 had to be transferred from his seat on the van to a whee1chair, so that he cou1d be taken back into the house. Staff K ro11ed c1ient onto the 1ift whi1e inside of the van, whi1e Staff C stood on the ground and prepared to operate the 1ift. The safety strap was not p1aced behind c1ient #4's whee1chair at the 1ift was 1owered to the ground. Interview on 6/5/19 with Staff H revea1ed he began working at the home about a month ago and does not usua11y secure whee1chairs on the van. Additiona1 interview indicated the staff had not been trained to secure whee1chairs on the van using tie-downs. Interview on 6/5/19 with Staff K revea1ed that he had worked at the home for five months. He shared that another staff (non-management) had trained him on operating the 1ift to the van but that no one had shown him how to use the safety strap whi1e using the 1ift. Staff K shared that he knew to use the safety strap due to experiences using a 1ift at previous jobs. Staff K stated that the strap wou1d prevent the chair from moving. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed staff genera11y 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 A BUILDING ~~~~~~~~~~~~~~~~~~~~~~~~~~ B WING ##########################06/05/2019	(X3) DATE SURVEY COMPLETED
	34G302		

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 individua1 program p1an must describe re1evant interventions to support the individua1 toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the faci1ity fai1ed to ensure c1ient #5's Individua1 Program P1an (IPP) inc1uded specific information to support the use of his eye g1asses. This affected 1 of 3 audit c1ients. The finding is: C1ient #5's IPP did not inc1ude information regarding the use of his eye g1asses. During observations throughout the survey on 6/4 - 6/5/19, c1ient #5 did not wear eye g1asses. The c1ient was not prompted or assisted to wear eye g1asses. Review on 6/5/19 of c1ient #5's IPP dated 11/16/18 revea1ed he did not wear eye g1asses. Additiona1 review of c1ient #5's record indicated he had a visua1 exam on 2/14/19 and a perscription for eye g1asses was given. Further review of the IPP did not inc1ude any specific information regarding the use of c1ient #5's eye g1asses. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professioa1 (QIDP) indicated c1ient #5 does have eye g1asses and has worn them for a whi1e. Additiona1 interview reveak1ed he shou1d be wearing them dai1y with staff prompting. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 240	The facility will ensure the individual program plan address interventions to support clients in activities of daily living and independent functioning. For Client #5, the QIDP will schedule a team meeting to address wearing of eyeglasses. The IPP will be updated to reflect the status based on input from the team and appropriate health service provider. An update to client #5's IPP relative to eyeglasses will occur. The QIDP will provide training to staff. In addition, during clinical meetings the team will review interventions as such which are applicable to other clients and update the IPP. QIDP and QA staff will monitor quarterly through record review and observations to ensure continued compliance.	8/2/19 8/2/19
W 249		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
PINE RIDGE GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
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 interdiscip1inary team has formu1ated a c1ient's individua1 program p1an, each c1ient 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 individua1 program p1an. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the faci1ity fai1ed to ensure 2 of 3 audit c1ients (#2 and #5) received a continuous active treatment p1an consisting of needed interventions and services identified in the Individua1 Program P1an (IPP) in the areas of medication administration and se1f-he1p ski11s. The findings are: 1. C1ient's medication administration objectives were not imp1emented during the administration of their medications. a. During observations of medication administration in the home on 6/5/19 at 7:45am, Staff J comp1eted a11 necessary tasks without prompting or assisting c1ient #5 to participate. During an interview with Staff J on 6/5/19, when asked if any of the c1ients have goa1s for medication administration, the staff stated, "I cou1dn't even te11 you." Interview with Staff C indicated a11 of the c1ients have goa1s for medication administration and c1ient #5 wi11 use the manua1 sign for 'medication'.	W 249	The facility will ensure implementation of individual program plan interventions to address medication administration strategies and self-help dining needs for all clients in the home. For Clients #2 and #5 the QIDP will provide in-service training to all staff in the home on medication administration training per the IPPs. Staff will be instructed to integrate the training for both clients during any and all medication pass opportunities in the home. The QIDP and home manager will monitor medication administration in the home on a weekly basis to ensure continued compliance.	8/2/19 8/2/19

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

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 c1ient #5's IPP dated 11/16/18 revea1ed an objective to communicate using sign 1anguage during medication administration for 90 consecutive days (imp1emented 3/18/19). The objective noted the c1ient shou1d sign 'medication'. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) confirmed the objective was current and shou1d have been imp1emented during medication administration. b. During observations of medication administration in the home on 6/5/19 at 8:10am, Staff J comp1eted various tasks and on1y prompted c1ient #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 c1ients have goa1s for medication administration, the staff stated, "I cou1dn't even te11 you." Additiona1 interview with Staff C indicated a11 of the c1ients have goa1s for medication administration. Review on 6/5/19 of c1ient #2's IPP dated 7/3/18 revea1ed an objective to independent1y participate in medication administration dai1y for 90 consecutive days (imp1emented 3/1/18). The objective inc1uded 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 shou1d have been imp1emented during medication administration. Additiona1 interview indicated c1ient #2 can retrieve his medication bin, punch his pi11s 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 comp1eted a11 necessary tasks without prompting or assisting c1ient #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 c1ients have goa1s for medication administration, the staff stated, "I cou1dn't even te11 you." Additiona1 interview with Staff C indicated a11 of the c1ients have goa1s for medication administration. Review on 6/5/19 of c1ient #4's IPP dated 11/21/18 revea1ed an objective to participate in medication administration dai1y for 90 consecutive days (imp1emented 3/21/19). Interview on 6/5/19 with the QIDP confirmed the objective was current and shou1d have been imp1emented during medication administration. It shou1d a1so be noted that a sheet posted on the door of the med room throughout the observatios indicated, "Incorportate c1ients in their med admin process to promote independence." 2. C1ient #5 was given fu11 physica1 assistance to consume his mea1s. 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 c1ient #5 with hand-over-hand assistance to consume his mea1. This fu11 physica1 assistance was provided intermittent1y at dinner and for the entire mea1 at	W 249	For Client #5 the QIDP will provide in-service training on the implementation of self-feeding per the IPP. Staff will be instructed to provide minimal support during meals. Staff will not provide HOH or full assistance to the client during meals. The QIDP and home manager will monitor meals in the home on a weekly basis to ensure staff promote independence in dining and self-feeding for all clients as applicable.	8/2/19

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 revea1ed c1ient #5 "hands shake" so he sometimes needs more assistance. Review on 6/5/19 of c1ient #5's IPP dated eats independent1y and needs "minima1 physica1 assistance" at mea1s. Interview on 6/5/19 with the QIDP indicated c1ient #5 can feed himse1f and does not require fu11 physica1 assistance whi1e eating.	W 249	The facility will ensure that the IPP is update for all clients to address revisions in training objectives. The QIDP will schedule team meetings for Clients #2 and # 5 to review all applicable training objectives. The team will revise and/or develop new training objectives to address priority needs based on the review of the comprehensive functional assessment. The QIDP will update monthly notes on status of training objectives for all clients.	8/2/19
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individua1 program p1an must be reviewed at 1east by the qua1ified menta1 retardation professiona1 and revised as necessary, inc1uding, but not 1imited to situations in which the c1ient is fai1ing to progress toward identified objectives after reasonab1e efforts have been made. This STANDARD is not met as evidenced by: Based on record reviews and interview, the faci1ity fai1ed to ensure the Individua1 Program P1an (IPP) was reviewed and revised as necessary. This affected 2 of 3 audit c1ients (#2, #5). The findings are: 1. C1ient #2's IPP was not reviewed as needed. Review on 6/5/19 of c1ient #2's IPP dated 7/3/18 revea1ed objectives to make a purchase 2 times per week, put away 1aundry for 8 consecutive weeks, fo11ow an infection contro1 routine dai1y for 90 consecutive days and to participate with the	W 257	The QIDP will in-service all staff in the home on the updated training objectives for clients #2 and #5, In addition, the team will review other cleints training objectives in the home and update as applicable. QA will monitor program objective status, the development and /or any updates of training on a quarterly basis to ensure continued compliance.	8/2/19

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

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 p1an indicated a11 objectives were imp1emented on 3/1/18. Additiona1 review of quarter1y progress notes revea1ed the 1ast progress review for the objectives was comp1eted on 1/10/19. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed she had not been ab1e to catch up with reviewing c1ient's objectives for progress and she cou1d not be sure if progress had been made over the past 5 months. 2. C1ient #5's IPP was not reviewed as needed. Review on 6/5/19 of c1ient #5's IPP dated 11/16/18 revea1ed an objective to se1ect a movie he 1ikes to watch for 24 consecutive weeks (imp1emented 3/1/18). Additiona1 review of quarter1y progress notes indicated no progress reviews for this objective. Further review of the p1an identified objectives to use the restroom dai1y for 90 consecutive days (imp1emented 3/15/18), participate with his ora1 hygiene routine for 90 consecutive days (imp1emented 3/1/18), make a purchase week1y for 8 consecutive weeks (imp1emented 3/15/18), identify activities to participate in dai1y for 90 consecutive days (imp1emented 3/15/18) and to communicate using sign 1anguage during medication administration dai1y for 90 consecutive days (imp1emented 3/15/18). Additiona1 review of quarter1y progress notes revea1ed the 1ast progress review for the objectives was comp1eted on 1/10/19. Interview on 6/5/19 with the QIDP revea1ed 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 ab1e to catch up with reviewing c1ient's objectives for progress and she cou1d not be sure if progress had been made over the past 5 months.	W 257	The facility will ensure nursing services address client needs relative to monitoring of weights.	8/2/19
W 331	NURSING SERVICES CFR(s): 483.460(c) The faci1ity must provide c1ients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, nursing staff fai1ed to ensure that 1 of 3 audit c1ients (#4) had month1y weights recorded per physician's orders. The findings is: C1ient #4 did not have month1y weights recorded. Review on 6/4/19 of c1ient #4's physician's orders signed on 3/22/19 revea1ed that staff were supposed to "check weight month1y 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 c1ient #4's MAR from Dec 2018 to May 2019 revea1ed no weights were recorded on the back of the MAR in Jan, Feb, March and Apri1, 2019. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) acknow1edged that weighing c1ient #4 had been an issue because he wou1dn't be sti11 on the sca1e.	W 331	For client # 4, the nurse will have discussions with the QIDP and home manager to facilitate actions necessary for weights to be taken monthly per physician's orders. Client #4 will receive monthly weights in accordance with physician's orders. The monthly weights will be documented on the MAR. Weights for other clients will be taken and documented in accordance with physician's orders as applicable. QA and QP will monitor monthly to ensure continued compliance.	
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 a11 drugs are administered in comp1iance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the faci1ity fai1ed to ensure c1ient #4's medications were administered in accordance with physician's orders. This affected 1 of 3 c1ients observed receiving medications. The finding is: C1ient #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 Omeprazo1e/Bicarbonate powder ora1 suspension 40mg/1680mg. The staff added two tab1espoons of water to the powder and an undetermined amount of Thick-it powder, stirred it and presented it to c1ient #4. The c1ient refused the medication. At 8:40am, Staff J added a spoonfu1 of Ensure pudding to the medication mixture and fed it to c1ient #4. Interview with Staff J revea1ed they don't usua11y add pudding to that particu1ar medication but most other med techs do because they know he 1ikes pudding. Review on 6/5/19 of c1ient #4's physician's orders dated 3/22/19 revea1ed an order for Omeprazo1e and Bicarbonate powder ora1 suspension 40mg/1680mg (Zegerid 40mg packet), "empty the contents of 1 packet in a sma11 cup containing 2 tab1espoons of water. Stir we11 & drink once dai1y. Refi11 cup & drink. On1y use water, 8am"	W 368	The facility will ensure medications are administered to all clients in accordance with the physician's orders to include but not limited to medication mixtures. For Client # 4, the QIDP will provide in-service training to all staff on administration of medications. Staff will be advised to not add pudding to the medication mixture. QA, Home Manager and /or QP will monitor medication pass weekly in the home to ensure continued compliance.	8/2/19

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

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 28 Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) confirmed the medication shou1d have been administered as written on the physician's order.	W 368	The facility will ensure medications are administered to all clients without error.	8/2/19
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that a11 drugs, inc1uding those that are se1f-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the faci1ity fai1ed to ensure a11 drugs were administered without error. This affected 3 of 3 c1ients (#2, #4, #5) observed receiving medications. The findings are: 1. C1ient #5 did not receive a11 ordered medications. During morning observations of medication administration in the home on 6/5/19 at 7:45am, c1ient #5 ingested Ravicti, Tegreto1, Keppra, Latu1ose, Fycompa, Ca1cium Citrate p1us D3, Loratadine, Magnesium, One a Day Men's and Topiramate. Review on 6/5/19 of c1ient #5's physician's orders for 3/1/19 - 6/30/19 (dated 3/22/19) revea1ed orders for "F1onase .05% nasa1 spray, use 2 sprays in each nostri1 dai1y, 8am" and "K1onopin .5mg, take 1 tab1et by mouth twice dai1y, 8am, 8pm." Interview on 6/5/19 via phone with the faci1ity's	W 369	For Clients #2, #4 and #5, the QIDP will provide in-service training to all staff on administration of medications to include but not limited to pills, nasal spray and topicals. Staff will be advised to crosswalk the MAR and ensure all medications are administered. The home manager will, conduct observations of the medication administration 2 times weekly. Nurse, QA and /or QP will monitor medication pass weekly in the home to ensure continued compliance.	8/2/19

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 369	Continued From page 29 nurse confirmed c1ient #5's physician's orders were current. 2. C1ient #2 was not administered his F1onase as ordered. During morning observations of medication administration in the home on 6/5/19 at 8:10am, c1ient #2 ingested Fiscta1orpam, Gabapentin, Levothyroxine, Loratadine, Risperda1 and Vascepa. The c1ient a1so received one spray of F1onase nasa1 spray in each nostri1. Review on 6/5/19 of c1ient #2's physician's orders for 3/1/19 - 6/30/19 (dated 3/22/19) revea1ed an order for F1onase .05% nasa1 spray, " 2 puffs in each nostri1 once dai1y at 8am". Interview on 6/5/19 via phone with the faci1ity's nurse confirmed c1ient #2's physician's orders were current. 3. C1ient #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, c1ient #4 ingested Vimpat, Ferrous Su1fate, Docu Liquid, Cerovite, Vitamin B-1, Vitamin D, and Omeprazo1e/Sodium Bicarbonate powder. The c1ient was a1so administered Pataday . 2% eye drops. In addition, c1ient #2 received Hydrocortisone cream and Po1ysporin cream to both feet. Review on 6/5/19 of c1ient #4's physician's orders for 3/1/19 - 6/30/19 (dated 3/22/19) indicated orders for "Lamisi1 1% cream, app1y to affected area twice dai1y 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

(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 369	Continued From page 30 8pm" and "Lac-hydrin 1 2% cream, app1y to feet twice dai1y, 8am, 8pm". Interview on 6/5/19 via phone with the faci1ity's nurse confirmed c1ient #4's physician's orders were current.	W 369	The facility will implement a system to ensure that evacuation drills are conducted at varied times and conditions to include but not limited day time hours.	8/2/19
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The faci1ity must ho1d evacuation dri11s under varied conditions. This STANDARD is not met as evidenced by: Based on record review and interview, the faci1ity fai1ed to ensure fire dri11s were conducted at varying times and conditions. The finding is: Faci1ity fire dri11s were not comp1eted at varying times of the day. Review on 6/4/19 of faci1ity fire dri11 reports for June 2018 - June 2019 revea1ed on1y one fire dri11 had been conducted on 1/10/19 at 7:30am for first shift. Other times fire dri11s were conducted inc1uded ear1y morning hours of 5:06am, 1:31am, 1 2:07am, and 1 2:00am and evening hours of 4: 20pm, 6:00pm, 11:50pm, 7:50pm, 7:00pm, 5:55pm, and 7:11pm. No other fire dri11s had been conducted during daytime hours The fire dri11s were not conducted at varying times and conditions for first shift. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) indicated since c1ients are not in the home during day time hours throughout the week, fire dri11s cou1d be conducted during those hours on the weekend.	W 441	The QIDP and home manager will develop a schedule for staff in the home to implement evacuation drills that are reflective of varied times and conditions with special direction on including morning time intervals. The QP will in-service all staff on the update evacuation schedule with a specific emphasis on morning hours. The QIDP and home manager will monitor the evacuation drills on a monthly basis to ensure continuous compliance.	8/2/19

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 faci1ity must ensure that specific dietetic services requirements are met.** **This CONDITION is not met as evidenced by: The faci1ity fai1ed to ensure each c1ient received their modified and specia11y-prescribed diets. (W460).** **The cumu1ative effect of these systemic practices resu1ted in the faci1ity's fai1ure to provide statutori1y mandated Dietetic Services.**	W 459	The QP will coordinate onsite training to address modified and specially prescribed diets. The nutritionist will provide specific training to all staff on textured diets such as pureed and thickened consistency for fluids. The training will include demonstration on how to prepare the specially prescribed diets. A test will be administered to staff to ensure competencies in the preparation of modified diets.	7/19/19
W 460	**FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)** **Each c1ient must receive a nourishing, we11-ba1anced diet inc1uding modified and specia11y-prescribed diets.** **This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the faci1ity fai1ed to ensure 1 of 3 audit c1ients (#4) received a modified and specia11y-prescribed diet as indicated. The findings are:** **C1ient #4's appropriate food and drink consistency were not fo11owed at 3 of 3 mea1s.** **a. During observation of 1unch at the day program on 6/4/19 at 1 2:00 pm, c1ient #4 was being assisted with his mea1 by day program Staff F. C1ient #4 had a sectioned p1ate that contained a b1ended pasta cassero1e that had sma11 chunks of green vegetab1es in it, smooth pureed orange**	W 460	The facility will implement a more aggressive system of monitoring meals in the home by the home manager and QIDP. A mealtime assessment tool will be implemented to track staff competencies. Management will provide onsite training as needed during monitoring of meals to improve staff competencies.	7/19/19
			For Client #4 the staff at the day program will be in-service by QIDP on the IPP relative to feeding skills. Staff will be advised not to feed the client, only provide minimal support per the IPP. The QIDP and/or Home Manager will monitor meals at the day program weekly to ensure continued compliance.	7/19/19

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 3 2 je11o and squash. In a Styrofoam cup was a red beverage. C1ient #4 on1y showed interest in drinking the red beverage. At 1 2: 25 pm, Staff F fi11ed c1ient #4's cup with water and added 2 scoops of thickener, stirring the contents and offered it to c1ient #4 who starting to drink from the cup. At 1 2:30 pm, c1ient #4 was observed to cough repeated1y whi1e finishing his drink. Staff F patted c1ient #4 on his back, as c1ient #4 hung his head 1ow whi1e seated. C1ient #4 was offered his food, refusing to eat the pureed squash and je11o. C1ient #4 started to eat the pasta and was not prompted to take sips of beverage between bites. At 1 2:43 pm, c1ient #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 4:5 2 pm, the b1ender contained peas and carrots with no 1iquid added. Staff D turned on the b1ender for about 20 seconds and b1ended the food. There were sti11 noticeab1e green and orange sma11 chunks of the vegetab1es, as Staff D transferred the food on the sectioned p1ate. Next, Staff D scooped chicken and dump1ings with broth into the b1ender, and processed the food for 1ess than 10 seconds, with some visib1e vegetab1es remaining in the pureed texture. The food was presented to c1ient #4, who wou1d not eat anything except for the choco1ate pudding. After c1ient #4 ate the pudding, Staff A p1aced 4 scoops of thickener into a 4 ounce cup of tea and offered it to c1ient #4, but he did not take any sips. Instead c1ient #4 took a few bites of the chicken and dump1ings. At 5: 28 pm, Staff A put the g1ass of tea in front of c1ient #4 but did not verba11y prompt him to take sips. C1ient #4 reached for the g1ass of tea and took severa1 sips, before he was 1ed out of the room for a wardrobe change.	W 460	For Client #4 the staff at the day program and home will be in-service on his diet of pureed food and thicken liquids. The QIDP and the Nutritionist will provide in-service training to day program and group home staff on the presentation of pureed foods and thicken liquids. The day program staff will check the lunch upon client #4 arrival and will contact the QIDP Immediately if the food consistency is not pureed and the liquids is not thickened in accordance with the diet. All staff assigned to the home will be responsible for verifying the correct consistency of food (pureed) and thickened beverages before presentation to Client #4 at any given meal. This check and balance system will afford multiple staff focus on the consistency of food and beverages per physician's orders. In addition, all staff assigned to the meal will communicate and verify all prescribed diets before presentation to the clients for consumption.	7/19/19 7/19/19

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

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
	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 b1ender to puree the oatmea1 for c1ient #4's breakfast. At 6: 28 am, c1ient #4 sat next to Staff J who has a1ready scooped an undetermined amount of thickener in a 6 ounce g1ass of tea and was stirring the contents. C1ient #4 had a section p1ate with smooth pureed scramb1ed eggs and french toast sticks and 1umpy oatmea1 with pieces of b1ueberries. C1ient #4 started to feed himse1f, eating the oatmea1. At 6:38 am, Staff J asked Staff K if there were b1ueberries in the oatmea1 and Staff K responded that it contained b1ueberries and bananas. C1ient #4 did some infrequent coughing as he continued to eat his mea1 and Staff J patted him on his back. C1ient #4 did not take any sips of f1uids during his mea1 and was not prompted by staff. C1ient #4 went to sit down in a chair, after eating breakfast. Staff J brought the tea to him and a1so prepared a 4 ounce cup of mi1k that had 2 tab1espoon of thickener p1aced in it. C1ient #4 drank the tea, then drank his mi1k. The container of unf1avored thickener was examined. It stated to reach nectar consistency, 4-5 tab1espoon shou1d be added to the beverage and then a11ow the beverage to sit for 30 seconds. The instructions did not specify if adjustments shou1d be made based on the amount of f1uid ounces in the g1ass. Review on 6/4/19 of the Annua1 Nursing Summary dated on 2/21/19 revea1ed that c1ient #4 was on a pureed diet with thicken 1iquids, due to a choking incident in March 2014. C1ient #4 was noted by the nurse to be an aspiration risk. Additiona1 review of the physician's orders signed 3/22/19 revea1ed that c1ient #4 was on a pureed diet with nectar consistency and shou1d take	W 460	The home manager and QIDP will monitor meals in the home and day program weekly to ensure continued compliance. A re-in-service will be provided by management while onsite if staff fail to present food in correct consistency in accordance with the IPP and physician's orders.	7/19/19

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

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 34 sma11 bites with sips. Review on 6/5/19 of c1ient #4's Speech Language Patho1ogy Initia1 Eva1uation dated 2/19/19- revea1ed that c1ient #4 was diagnosed with oropharyngea1 dysphasia (swa11owing disorder) and that c1inica1 rick factors for aspiration that were present during the assessment, was that he produced a wet/aphonic voca1 qua1ity (inadequate voice support to produce inte11igib1e speech) after swa11owing. Factors compounding risk of aspiration was c1ient #4's cognitive deficits and dependence on feeding. Observations inc1uded that c1ient #4 had pro1onged ora1 ho1ding of pureed intake. He had questionab1e wet voca1 qua1ity but otherwise had no signs or symptoms of aspiration. C1ient #4 had 7 more pureed tria1s by 2/21/19 and was discontinued from speech 1anguage patho1ogy treatment after demonstrating no overt signs or symptoms of aspiration. It was recommended that c1ient #4 shou1d a1temate so1ids and 1iquids, and take sma11 bites and sips. An additiona1 review on 6/4/19 of the Dietary Inservice dated 4/7/18, which hung on the faci1ity's kitchen wa11, revea1ed that when preparing a modified diet of pureed consistency, food is smooth, moist and 1ump free; may have a grainy texture; thickened 1iquids at nectar thick, f1uid runs free1y off the spoon but 1eaves a mi1d coating on the spoon. When using a thickening powder or thickening agent, staff were to fo11ow the instructions on container. It further added that signs and symptoms of choking, inc1ude strugg1ing to breathe (gasping), coughing, gagging, and b1uish 1ips 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 A BUILDING ~~~~~~~~~~~~~~~~~~~~~~~~ B WING ##########################06/05/2019	(X3) DATE SURVEY COMPLETED
	34G302		

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 35 revea1ed that the group home did not send a consistent pureed texture, when preparing pasta or meat items in c1ient #4's 1unch. Staff F shared that today, it did not appear that c1ient #4 was given a pureed texture with his pasta dish. In the past, the c1assroom has had to use their b1ender to further process c1ient #4's food before offering it to him. On other occasions Staff E has ca11ed the group home and informed them that the diet texture was not consistent with pureed diet. Staff F a1so commented that when she attempted to thicken his (c1ient #4's) drinks to a Nectar texture, she tried to have the beverage resemb1e a "s1ushie drink". Staff F revea1ed that she had not received any written instructions on his (c1ient #4's) feeding protoco1 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 revea1ed that she worked in the home for five years and monitored the consistency of the drink, when thickening a 1iquid. She stated that she "used 2 tab1espoon of thickener powder in the tea and the mi1k." Interview on 6/5/19 with Staff C revea1ed that when she prepared the oatmea1 she did not add water because " it 1ooked 1ike it did not need it." She added that the b1ender used was "very powerfu1 and it makes everything pureed." When Staff C was asked about the b1ueberries in c1ient #4's oatmea1, she responded that "they were very fine and came out in his (c1ient #4's) stoo1." Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed 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	W 460		

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

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 wou1d norma11y 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 sti11 had mea1 preparation privi1eges. It was noted that Staff C did not attend the training on 5/30/19. During a further interview with the QIDP, in re1ation to preparing a pureed diet for c1ient #4, she commented that she wanted staff to prepare it to 1ook 1ike "baby food." The QIDP acknow1edged that she did not give any specific instructions on how to achieve a pureed texture, but had provided hands on demonstration with staff and a1ways "harped on them" (staff) to make sure his (c1ient #4) food was right. The QIDP commented that she cou1d on1y reca11 getting one ca11 from the day program about six months ago that c1ient #4 did not receive an appropriate pureed texture for 1unch. She made month1y visits to the group home and had been present for mea1s and had not observed any prob1ems with the consistency of c1ient #4's modified diet. The QIDP commented that because of c1ient #4 having dysphasia, staff shou1d a1ternate 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 utensi1s. 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 faci1ity fai1ed to ensure c1ient #4's adaptive dining utensi1s were uti1ized at mea1s. This affected 1 of 3 audit c1ients. The finding is: 3. C1ient #4 was not given the proper adaptive utensi1s at mea1s. During a dinner observation on 6/4/19 at 5:00 pm, c1ient #4 was using a regu1ar spoon to eat choco1ate pudding from a sectioned p1ate. An additiona1 breakfast observation on 6/5/19 at 6:45 am, revea1ed c1ient #4 was using a regu1ar spoon to feed himse1f modified texture oatmea1, scramb1ed eggs and french toast sticks. Review on 6/4/19 of c1ient #4's Nutritiona1 Eva1uation dated on 8/16/18, revea1ed that adaptive equipment needed at his mea1s inc1uded a section p1ate with bui1t up utensi1s. In addition, the IPP dated on 11/21/18 revea1ed c1ient #4 required staff's assistance with eating to use a11 utensi1s correct1y. Interview on 6/5/19 with the Qua1ified Inte11ectua1 Disabi1ities Professiona1 (QIDP) revea1ed 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 c1ients had adaptive equipment, as ordered, provided to them.	W 475	The facility will ensure that clients utilize adaptive equipment during meals as indicated by the IPP. Adaptive equipment will be utilized by clients in the home and day program in accordance with the Individual Support Plans. For Client #4 the staff at the day program and home will be in-service on his use of section plate and built up spoon. The QIDP will provide in-service training to staff in the home and the day program on use of adaptive equipment for Client #4. The QIDP and/or Home Manager will monitor meals at the day program and home weekly to ensure continued compliance.	7/19/19 7/19/19

June 26, 2019

Ms. Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual Recertification Survey completed June 5, 2019
Pine Ridge Group Home
739 Arthur Maddox Road, Sanford, NC 28322
MHL#053-027, Provider # 34G295

Dear Ms. Worsley-Diggs:

See attached hard copy of the plan of correction (POC) for the Pine Ridge survey. We respectfully request a re-visit on July 19, 2019 as we would have taken the necessary steps to come into compliance with the Condition Level Deficiency 483.480 Dietetic Services (W459). See attached POC.

We hope that you will find the attached POC acceptable. If you have questions, feel free to contact me directly or Laura Jacobs. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

TB

Tonya Beckwith, QP - Community Innovations