STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G256	A. BUILDING _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE RESIDENTIAL	353 ELM STREET FAIR BLUFF, NC 28439

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client (#4) had a updated legal guardian appointed by the court. This affected 1 newly admitted client. The finding is: Client #4 guardianship paperwork is not updated. Review on 7/29/19 of client #4's record revealed guardianship paperwork with his sister and mother listed as his legal guardians dated 10/12/90. Review on 7/29/19 of client #4's record revealed he has a behavior support plan consent dated 7/2/19 which consists of the following medications for maladaptive behaviors: Carbamazepin, Velafaxine, Saphris and Fluphenazine. During an interview on 7/29/19, the qualified intellectual disabilities professional (QIDP) revealed client #4's mother has been deceased "for awhile." Further interview revealed the QIDP had spoken to client #4's sister about obtaining updated guardianship paperwork, but it has not been none yet. Additional interview revealed client #4's guardianship paperwork is not current.	W 125	**W 125** **The facility will ensure each client has updated paperwork reflecting of current guardianship status upon admission as well as throughout the duration of stay with the facility.** **1. Clinical Supervisor will ensure that the appropriate legal documentation regarding guardianship of all clients new and/or currently residing in facility is update immediately when changes occur.** **2. The facility will secure guardianship letters reflective of the current court appointed status of client #4. The aunt and cousin will be filing a motion to the clerk for an update on the guardianship. The Clinical Supervisor will document the status of the motion in the client's record.** DHSR - Mental Health AUG 15 2019 Lic. & Cert. Section	9/27/19
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Williams — TITLE: Clinical Supervisor — (X6) DATE: 8/7/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	Continued From page 1 formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of medication administration and ambulation. This affected 2 of 3 audit clients (#1, #4). The findings are: 1. Client #4's physical therapy recommendations were not followed. During evening observations in the home on 7/29/19 at 5:52pm, a staff person verbally prompted client #4 to leave the dining room table and retrieve his Boost drink from the refrigerator. Client #4 stood up and ambulated 40 - 45 feet into the kitchen opened the refrigerator door and took out his Boost. Additional observations revealed Staff B told client #4 to ambulate back to the dining room table with his Boost. Client #4 returned back to the table. At no time was a staff person holding onto client #4's gait belt while he ambulated. Client #4 was wearing the gait vest while he was ambulating. During an interview on 7/29/19, Staff B revealed client #4 has the gait vest because he has a	W 249	W 249 The facility will ensure that each client receives a continuous active treatment plan consisting of needed interventions/tools and services identified in the IPP to address use of gaite vest and implementation of medication administration 1. Physical Therapist will in-service all staff on proper usage of support devices (gait vest) when clients are assessed and new supports are needed. PT will in service staff on use of client #4 gait vest. Program Manager and Clinical Supervisor will monitor proper usage of supportive devices (gait belt) weekly.	9/20/19

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W 249	Continued From page 2 history of falls, "but hasn't fallen since he's been living here." Additional interview revealed client #4 has not been living in the home quite yet a year. Staff B revealed staff probably should have been holding onto his gait vest while he ambulated back and forth from the dining room table. Review on 7/29/19 of client #4's IPP dated 5/16/19 stated, "[Client #4] is ambulating using a gait vest & staff assistance." Review on 7/29/19 of client #4's occupational therapy (OT) evaluation dated 6/27/19 revealed, "Ambulate with gait vest for balance and safety during transfers." Review on 7/29/19 of client #4's physical therapy (PT) evaluation dated 5/7/19 stated, "Equipment: 2 strap belt vest for balance and safety during transfer and ambulation." Further review revealed, "Recommendation: 1. Continue use of gait vest belt...." During an interview on 7/29/19, the qualified intellectual disabilities professional (QIDP) revealed client #4's gait vest is to be used at all times. The QIDP also revealed client #4's gait vest is used to his history of falling. 2. Client #1 was not afforded full participation in medication administration. During morning medication administration on 7/30/19 at 9:10am, Staff A fed client #1 his medications, which were in pudding. Further observations revealed client #1 independently eating the remainder of the pudding after he was spoon fed his medications.	W 249	**2. Habilitation Specialist will ensure that client #1 is afforded the opportunity to assist with medication administration to his highest potential identified in a goal and in-service staff. Nursing staff will in service all staff on medication administration and allowing clients to participate as much as possible. Program manager and Habilitation specialist will monitor weekly. Nursing staff and clinical supervisor will monitor monthly.**	

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W 249	Continued From page 3 During an interview on 7/30/19, Staff A revealed she client #1 should have been given the opportunity to self feed his medications. Review on 7/29/19 of client #1's IPP dated 10/16/19 revealed he eats independently. Review on 7/30/19 of client #1's nutritional evaluation dated 10/22/18 revealed he feeds himself. Review on 7/30/19 of client #1's adaptive behavior inventory (ABI) dated 7/26/18 revealed he is totally independent with taking his own pills. During an interview on 7/30/19, the QIDP confirmed client #1 should have been given the opportunity to feed himself his medications.	W 249		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 newly admitted client (#4) received an adequate annual physical. The finding is: Client #4 did not receive a current audiological examination to review. Review on 7/29/19 of client #4's record revealed a physical examination dated 4/17/19. There	W 323	W323 The facility will ensure all new admission clients are scheduled for required medical assessments within the first 30 days of admission. Nursing staff will schedule new admission clients for all medical evaluations upon admissions and ensure they are completed within the first 30 days. Nursing staff will also ensure that all annual assessments are completed. Nursing staff will schedule client #4 for audiological examination. Nursing staff and Clinical supervisor will evaluate client medical record monthly to ensure all annual assessments are completed upon due dates.	9/20/19

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W 323	Continued From page 4 was not current information available for review to indicate the audiological examination was performed. During an interview on 7/30/19, the qualified intellectual disabilities professional (QIDP) confirmed client #4 did not receive his audiological examination.	W 323		
W 324	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(ii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all immunizations were current for 1 newly admitted client (#4). The finding is: A record of client #4's immunizations was not kept. Review on 7/29/19 of client #4's record revealed he was admitted to the facility on 4/16/19. Additional review of his record revealed no immunization record. During an interview on 7/30/19, the qualified intellectual disabilities professional (QIDP)confirmed client #4's record did not have his immunization record.	W 324	**W 324** **The facility will ensure all new admission clients immunization records are obtained within the first 30 days of admission.** **Nursing staff will ensure that client #4 immunization record is obtained and in medical record. Nursing staff will ensure upon admission that all medical information/notes/needs are obtain upon admission date. Nursing staff will monitor medical records monthly to ensure all current documentation is in medical record. Clinical supervisor will monitor over first 30 days to ensure all documents are in medical record and monitor monthly to ensure any new information is needed and obtained.**	9/20/19
W 382	DRUG STORAGE AND RECORDKEEPING	W 382		

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W 382	Continued From page 5 CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The finding is: The medications were left unsecured and unsupervised. During morning medication administration in the facility on 7/30/19 at 8:35am, Staff A left the medication area. Further observations revealed there were medications left on the counter, unsecured and unsupervised. At 8:48am, Staff A left the medication area, while the surveyor was left in the room with the medications unsecured and unsupervised. During an immediate interview, Staff A confirmed she had left the medications unattended. Further interview revealed Staff A had been trained not to leave medications unattended. During an interview on 7/30/19, the facility's nurse stated, "medications should be secured at all times."	W 382	W 382 The facility will ensure all drugs and biologicals are locked safely during medication administration. Nurse will in serice all staff on proper way to secure the medication when leaving the medication room while medications are being administered. Nrse will monitor weekly. Clinical Supervisor will monitor monthly.	9/27/19
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses,	W 436	W436 The facility will ensure that all clients are taught to use and make informed choices about the use of any adaptive devices identified by the interdisciplinary team as needed by client.	9/27/19

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W 436	Continued From page 6 hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client # 4 had a recommended wheelchair. The finding is: Client #4 was not provided with a recommended wheelchair. During review on 7/29/19 of client #4's individual program plan (IPP) dated 5/16/19 stated, "A wheelchair is needed for longer distances, but he did not have one upon arrival & one has not been obtained at this time." During review on 7/30/19 of client #4's physical dated 4/17/19 revealed, "Wheelchair is needed for long distances." During an interview on 7/30/19, the qualified intellectual disabilities professional (QIDP) confirmed a wheelchair needs to be purchased for client #4.	W 436	**The Nursing staff will ensure that all medically necessary adaptive devices are with newly admitted clients and obtained for individuals when noted by physicians/occupational therapist/physical therapist/speech therapist and any other medical personnel as needed. Nursing staff and facility will ensure that client #4 has a wheelchair as identified in his IPP and medical assessment.**	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 1, 2019

Melissa Bryant, Division Director
Community Innovations
80 Alliance Drive
Whiteville, NC 28472

Re: Recertification Survey July 29 - 30, 2019
Riverside Residential, 353 Elm Street, Fair Bluff, NC 28439
Provider Number 34G256
MHL# 024-021
E-mail Address: mbryant@communityinnovations.com

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification survey completed on July 30, 2019.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **September 27, 2019**.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and***

please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182.

Sincerely,
Eugina Barnes

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: DHSRreports@eastpointe.net
File