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

PRINTED: 02/12/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G232	A. BUILDING ______ B. WING ______	02/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to perform their duties effectively. The finding is: The Medication Technician (MT) was not sufficiently trained to document on the Medication Administration Record (MAR). During observations in the home on 2/10/20 at 3:57pm and 4:46pm, the MT used the MAR to compare medication packets and assisted two clients with their medications. Once completed, the MT closed the MAR and left the area with the clients. The MT was not observed to sign the MAR after the clients had ingested their medications. Interview on 2/11/20 with the MT revealed they had been trained to compare pill packs with the MAR and sign the MAR before clients consumed their medications. Review on 2/11/20 of the facility's medication administration training (no date) indicated, "...it is important to document correctly. Never sign for giving a med until you actually see the client take the medication..." Interview on 2/11/20 with the facility's nurse	W 189	W189 The facility will provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently and competently. DHSR - Mental Health MAR 3 2020 Lic. & Cert. Section Nurses will train staff on correct method of documenting medication administration. They will in service staff on a continuous basis to ensure staff is appropriately documenting. Nurses and Program Manger will monitor weekly and QP will monitor monthly.	4/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharbara Williams — TITLE: Clinical Supervisor — (X6) DATE: 2/28/20

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 189	Continued From page 1 confirmed MTs are trained to sign the MAR after clients have ingested their medications, not before.	W 189		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the Individual Program Plan for 2 of 3 audit clients (#3, #6) included objectives to address their needs. The findings are: A. Client #3's IPP did not include training to address his medication administration needs. During observations of medication administration at the day program on 2/11/20 at 8:35am, client #3 was prompted to the medication area for his morning medications. The client participated with the administration of his medications by identifying his bin, pouring his water, applying a topical gel and ingesting his medications. Staff C obtained all pill packs, opened the pill packs, placed pills into a cup, gave them to the client and threw away trash. Interview on 2/11/20 with Staff C revealed client #3 can dispense his pills; however, he drops them at times.	W 227	W227 The facility will assure each clients IPP states the specific objectives necessary to meet the client's needs.	4/10/20

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W 227	Continued From page 2	W 227		

Review on 2/11/20 of client #3's Adaptive Behavior Inventory (ABI) dated 7/22/19 revealed he can come to the medication area with a prompt independently and has partial independence with taking his pills with water. The ABI indicated he has no independence with punching pills, measuring liquids or applying topicals. Additional review of the client's IPP dated 9/18/19 identified needs with learning the location of medications. learning to self administer medications and learning the time medications are given. Further review of client #3's IPP did not include objectives to address his medication administration needs.

During an interview on 2/11/20, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #3 could be participating more during the administration of his medications; however, no goals have been implemented in this area.

B. Client #6's IPP did not include training to address his medication administration needs.

During observations of medication administration in the home on 2/11/20 at 8:01am, client #6 was assisted to the medication area. As the client sat in a chair in the room, Staff C obtained all pills, placed the pills into a medication cup, poured the client's water, placed the pills in applesauce, fed the pills to the client, and threw away trash. Client #6 participated with the administration of his medications by swallowing his pills.

Interview on 2/11/20 with Staff C revealed client #6 does not assist with the administration of his medications.

Provider's Plan of Correction (W 227):

QP will update client #3 and #6 IPP's to ensure that training addressing mediation administration is included. Habilitation Specialist will develop goals based off of ABI assessment and inservice staff on training steps. Habilitation Specialist and Program Manager will monitor weekly. QP will monitor monthly.

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W 227	Continued From page 3 Review on 2/11/20 of client #6's ABI dated 9/11/19 revealed he can independently come to the medication area with a prompt and can take his pills and water and apply topicals given partial independence. The ABI noted no independence with measuring liquids and punching pills. Additional review of the client's IPP dated 9/23/19 identified needs with learning the location of medications, learning the time medications are given, learning side effects of medications and learning to self administer medications. Further review of the plan did not include objectives to address client #6's medication administration needs. During an interview on 2/11/20, the QIDP acknowledged client #6 can participate with simple tasks during medication administration; however, no training objectives have been identified in this area.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#6) received a continuous active	W 249	W249 The facility will ensure that each client receives a continuous active Treatment Plan, consisting of needed interventions/ tools and services identified in the IPP in the area of eating meals based off of swallow guidelines/rate of eating.	4/10/20

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W 249	Continued From page 4	W 249		

treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of implementation of mealtime guidelines. The finding is:

Client #6's mealtime guidelines were not implemented as written.

During dinner observations in the home on 2/10/20 from 6:03pm - 6:28pm, after client #6's food was cut up in the kitchen, Staff F sat next to the client at the meal. The client was provided hand-over-hand assistance to scoop his food and bring his spoon to his mouth. As client #6 consistently used his left hand to grab food from his plate, the Home Manager excused Staff F and began providing client #6 with hand-over-hand assistance with scooping and feeding. A knife was placed in the client's left hand as he continued to grab food. Once he dropped the knife, a small cup of water was placed in his left hand. Throughout the meal, client #6 was not provided verbal prompts to 'slow down', to chew his food, to wait 5 seconds between bites or to drink liquids throughout the meal.

Interview on 2/10/20 with Staff F revealed client #6 should be allowed to start feeding himself and if he begins eating too fast, they should give him hand-over-hand assistance to feed himself.

Review on 2/10/20 of client #6's IPP dated 9/23/19 revealed rate of eating guidelines dated 2/1/18. The guidelines noted, "...Staff should allow [Client #6] three attempts to eat independently with verbal prompts. If [Client #6] appears to have problems eating independently, due to excessive spillage, staff should then

QP and Habilitation Specialist will train staff on outlined guidelines for client #6 rate of eating/swallow guidelines. QP and Habilitation Specialist will inservice all staff on rate of eat Guidelines regularly and as needed. Habilitation Specialist and Program Manager will monitor weekly. QP will monitor monthly.

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W 249	Continued From page 5 provide hand-over-hand assistance. Staff should use hand-over-hand assistance when [Client #6] is cutting/chopping his food. If [Client #6] does not respond to the cue to slow down his rate of eating (after the second cue), encourage him to drink some of his fluids and proceed to the behavior chain... 1. Takes eating utensil of food to his mouth 2. Place eating utensil inside plate or hold in hand 3. Chews food (staff may need to encourage [Client #6] to chew throughout the meal) 4. Swallows food (encourage [Client #6] to wait 5 seconds before he puts more food into his mouth also encourage [Client #6] to take a drink of his liquids during these 5 seconds) 5. Repeat steps 1 - 4 until meal is finished If [Client #6] starts to scoop food from his plate with his free hand, staff should encourage him to hold a napkin/drink in that hand." Interview on 2/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the mealtime guidelines were current and staff should continue to follow them as written.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive Behavior Support	W 263	W263 The Facility will ensure that a written informed consent from all legal guardians is obtained for all clients with a BSP.	4/10/20

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W 263	Continued From page 6 Plans (BSP) for 2 of 3 audit clients (#3, #6) included written informed consent from the guardian. The finding are: A. Client #3's BSP did not include consent from his guardian. Review on 2/10/20 of client #1's record revealed a restrictive BSP dated 10/4/19 to exhibit 1 or fewer challenging behaviors of aggression, self-injurious behaviors, property destruction and severe disruption 11 consecutive months. Review of the plan also identified the use of Lithium, Clonzapam, Fanapt, Inderal, Celexa, Trazodone and Thorizine to address behaviors. Further review of the BSP indicated no written informed consent was available for the plan. Interview on 2/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated written informed consent for client #3's BSP had been sent to the guardian; however, it had not been returned. B. Client #6's BSP did not include consent from his guardian. Review on 2/10/20 of client #1's record revealed a restrictive BSP dated 11/20/19 to exhibit 1 or fewer challenging behaviors of aggression and severe disruption for 11 consecutive months. Review of the plan also identified the use of Risperdal and Depakote to address behaviors. Further review of the BSP indicated no written informed consent was available for the plan. Interview on 2/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated written informed consent for client #6's BSP had been	W 263	QP will contact guardian and have a written informed consent signed for client #3 an #6 BSP. QP will monitor monthly and/or when updated.	

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W 263	Continued From page 7 sent to the guardian; however, it had not been returned.	W 263		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 3 clients (#6) observed receiving medications. The finding is: Client #6's foot care solution was not administered as ordered. During observations of medication administration at the day program on 2/11/20 at 8:20am, client #6 received Betadine solution 10% between all toes on both feet. Review on 2/11/20 of client #6's physician's orders dated 11/6/19 revealed, "10% Povidone Solution (Betadine), apply to 4th webspace on rt foot twice daily after bath...8am, 8pm". Additional review of a nurse's note dated 7/9/19 indicated, "...podiatrist for nail debridement, Note instructs to D/C Betadine on (Left) foot but continue to apply it to 4th webspace on (Right) foot only..." Interview on 2/11/20 with the facility's nurse confirmed the Betadine should only be applied to client #3's fourth webspace on his right foot as	W 368	W368 The facility will ensure that all drugs are administered in compliance with physician's orders for all clients. Nurses will train all staff on client #6 MAR's and Physician orders. Nurses will train and inservices staff on reading MAR's, administering medications, applying topical/cream medications and documenting given medications. Nurse will in-service staff on proper administration of all medications regularly. Nurses and Program Manager will monitor weekly and QP monthly	4/10/20

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W 368	Continued From page 8 indicated by his physician's orders.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING 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, record review and interviews, the facility failed to ensure all medications remained locked when not being administered. The findings are: Medications were not kept locked at the home and the day program. During evening observations of medication administration in the home on 2/10/20 at 4:47pm, the Medication Technician (MT) (Staff F) exited the medication area into the kitchen. The door to the medication closet was not locked. During morning observations of medication administration at the day program on 2/11/20 at 8:26am and 8:55am, the MT (Staff C) exited the medication area on two separate occasions to retrieve clients. During these times, the door to the medication area was left wide open. Interview on 2/10/20 with the Staff F confirmed the door to the medication closet was not locked and they had been trained to keep the closet door locked to be "on the safe side". Interview on 2/11/20 with the Staff C confirmed the door to the medication area had been left	W 382	W382 The facility will ensure all drugs and biologicals are locked safely except when being administered. Nurse will in-service all staff on the proper way to secure the medications and room when leaving the are while medications are being administered. Nurses and Program Manager will monitor weekly and QP will monitor monthly.	4/10/20

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W 382	Continued From page 9 open. Review on 2/11/20 of medication administration training information (no date) indicated, "The medication storage area should always be locked, except when in use. When you leave the area to return the client and bring another one in, you must lock the door." Interview on 2/11/20 with the facility's nurse confirmed the door to the medication area/closet should be kept locked when the MT leaves the area.	W 382		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. The finding is: Facility fire drills were not completed at various times and conditions for one of three shifts. Review on 2/10/20 of facility fire drill reports for February 2019 - January 2020 revealed 4 first shift drills were conducted at 7:03am, 7:50am, 7:30am and 7:40am. The fire drills were not conducted at varying times and conditions on first shift. Interview on 2/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the drills were not conducted at various times on first	W 441	W441 The facility will ensure fire drill are conducted at various times and days while clients are awake and asleep. QP will inservice all staff on appropriate times and days to conducted monthly fire drills during wake and sleep hours. Program manger will in services staff regularly. QP and Program Manager will monitor monthly.	4/10/20

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W 441	Continued From page 10 shift.	W 441		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #3's specialized diet was followed as indicated. This affected 1 of 3 audit clients. The finding is: Client #3 did not receive his diet as indicated. During lunch observations at the day program on 2/10/20 at 11:28am, client #3 consumed a single pork chop, a serving of macaroni and cheese and a double portion of peas. During dinner observations in the home on 2/10/20 at 6:03pm, client #3 was assisted to serve himself a single pork chop, a serving of peas/carrots, a serving of yams, a slice of bread and a serving of applesauce. Interview on 2/10/20 with Staff B revealed client #3 is served double portions of all food items. Review on 2/10/20 of client #3's IPP dated 9/18/19 and physician's orders dated 11/6/19 indicated he should receive double portions at all meals. Interview on 2/11/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client	W 460	W460 The facility will ensure that each client receives a nourishing well-balanced diet including modified and specially prescribed diets. QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #3. QP and Habilitation Specialist will in-service all staff on the correct measurements for double portions. Habilitation Specialist and Program Manager will observe and monitor weekly. QP will monitor monthly	4/10/20

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W 460	Continued From page 11 #3 should receive double portions of food items at all meals.	W 460		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

February 13, 2020

DHSR - Mental Health
MAR 3 2020
Lic. & Cert. Section

Ms. Melissa Bryant, Division Director
Community Innovations, Inc.
80 Alliance Dr.
Whiteville, NC 28472

Re: Recertification Survey Completed February 10 -11, 2020
Northridge Residential, 68 Mitchell Ford Rd., Clarkton, NC 28433
Provider Number: 34G232
MHL Number: MHL009-009
E-mail Address: mbryant@communityinnovations.com

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification survey completed February 11, 2020. This survey was required for continued participation in the Medicaid program.

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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 10, 2020.

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.**

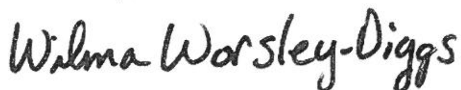
Send the original completed form to our office at the following address within 10 days of receipt of this letter.

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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow-up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Wilma Worsley-Diggs at 919-612-5520.

Sincerely,



Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: DHSRreports@eastpointe.net
File