

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

PRINTED: 02/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 WESTRIDGE ROAD GREENSBORO, NC 27405
--	--

(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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of records and interview, the person centered plan (PCP) for 1 non sampled client (#1) failed to include sufficient training objectives to meet identified needs relative to promoting self independence. The finding is:</p> <p>During observations in the group home on 2/19/2020 from 1:40 PM until 2:30 PM revealed client #1 to sit on the living room couch unengaged in any activities. Continued observations from 4:00 PM to 5:30 PM revealed client #1 to sit unengaged on the couch finger flicking and feeling the fabric on his pants and a towel. During this time, observations revealed staff C verbally prompted client #1 to come the table to play games but client #1 did not. Staff were able to prompt client #1 at 4:00 PM, 4:45 PM and 5:10 PM to carry a laundry basket, hold the laundry detergent, and wash his hands. Further observations at 5:45 PM revealed client #1 to sit on the floor in the dining room area before sitting in chair to begin eating dinner at 6:05 PM. Following dinner at 6:30 PM, client #1 got up, and refused to take his dishes to the kitchen and then returned to the couch to sit unengaged until 7:45 PM.</p> <p>Review on 2/20/2020 of client #1's record</p>	W 227	<p>W 227</p> <p>The team will meet to determine the need for additional training objectives relative to promoting self independence for client #1 based on the Adaptive Behavior Inventory. The Habilitation Specialist will ensure the recommendations are addressed in the form of a formal program as needed and in-service all staff to ensure the programs are implemented per the team meeting. The Qualified Professional will revise the Person Centered Plan to include the results of the team meeting. The clinical team will monitor 2x a week for 1 month then on a routine basis through Interaction Assessments to ensure Participation and independence is encouraged for client #1 and all people supported to participate in activities to their maximum potential.</p> <p>In the future, the Qualified Professional will ensure all Person Centered Plans include objective training to address identified needs.</p> <p>By: 4/19/20</p>	
-------	---	-------	---	--

DHSR - Mental Health
MAR 10 2020
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mollisa White TITLE: Qualified Professional (X8) DATE: 3/5/2020

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.

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

PRINTED: 02/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2020
NAME OF PROVIDER OR SUPPLIER WESTRIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 WESTRIDGE ROAD GREENSBORO, NC 27405		
(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 227	Continued From page 1 revealed a person centered plan (PCP) dated 6/12/2019 with the following four objectives which includes: to rinse his hair, pull out chair to sit at the table, identify cup/spoon and close the bathroom door. Further review of the record revealed a behavior support program (BSP) dated 3/6/2019. Continued review of client #1's BSP revealed client #1 should be engaged frequently, especially when he has not exhibited a target behavior of wrist biting, head slapping or sitting on floor. Subsequent review on 2/20/2020 of client #1's record revealed an adaptive behavior inventory (ABI) completed 5/27/2019. Further review of client #1's ABI revealed he has the following needs in the areas of self-help, daily living, community living and recreation. Interview on 2/20/2020 with the qualified intellectual disabilities professional (QIDP) confirmed client #1 is in need of acquiring more skills. The QIDP further confirmed she and the habilitation specialist will together review client #1's ABI to determine his areas of need.	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.	W 249	W249 The Qualified Professional will in-service staff on utilizing adaptive equipment during medication administration for client #4 and all people supported. The team will monitor this via medication observations x1 a week for 1 month then on a routine basis to ensure adaptive equipment is utilized for medication administration.		

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

PRINTED: 02/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2020
NAME OF PROVIDER OR SUPPLIER WESTRIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 WESTRIDGE ROAD GREENSBORO, NC 27405	
(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 2 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure 1 non-sampled client (#4) received a continuous active treatment program consisting of needed interventions and services as identified in the person centered plan (PCP) in the area of adaptive equipment. The finding is: Evening observations on 2/20/2020 of medication administration at 7:30 PM revealed staff A crushed client #4's medications which included Simvastatin and a stool softener. Continued observations revealed staff A poured client #4's crushed medications into a medication cup of applesauce. Further observations revealed staff A then spoonfed client #4 his mixture of crushed medications and applesauce with a regular spoon. Interview on 2/20/2020 at 7:40 PM with staff A revealed client #4 has an adaptive spoon and he can feed himself with his adaptive spoon. Further interview with staff A confirmed client #4 should have been allowed to feed himself his mixture of crushed medications and applesauce. Interview on 2/20/2020 with the facility nurse and the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 has an adaptive spoon and he can feed himself. Further interview confirmed client #4 should have been allowed to feed himself the mixture of crushed medications and applesauce with his adaptive spoon.	W 249	In the future, the Qualified Professional will ensure staff are trained to utilize adaptive equipment for all People Supported during medication administration. By: 4/19/20	
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure	W 369		

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

PRINTED: 02/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2020
NAME OF PROVIDER OR SUPPLIER WESTRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 WESTRIDGE ROAD GREENSBORO, NC 27405		
(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	<p>Continued From page 3</p> <p>that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 3 sampled clients observed during drug administration (#4). The finding is:</p> <p>Evening observations on 2/20/2020 of medication administration at 7:30 PM revealed staff A crushed client #4's medications which included Simvastatin and a stool softener. Continued observations revealed staff A poured client #4's crushed medications into a medication cup of applesauce and administered the mixture to client #4.</p> <p>Interview on 2/20/2020 at 7:40 PM with the medication technician staff A revealed he is familiar with client #4's pureed diet consistency. Further interview revealed staff A crushes all of client #4's by mouth medications.</p> <p>Review on 2/20/2020 of client #4's records revealed a person centered plan (PCP) dated 3/28/2019. Further review of client #4's PCP revealed signed physician's orders dated 1/2020 which noted Simvastatin and the stool softener medications are not order crushed. Review of client #4's PCP revealed an annual nutrition assessment dated 1/20/2020 which documented client #4's diet is pureed consistency and was downgraded to pureed because of a stroke.</p> <p>Interview on 2/20/2020 with the facility nurse and the Qualified Intellectual Disabilities Professional</p>	W 369	<p>W369</p> <p>The Nurse will in-service all staff on Ensuring physician orders are followed for client #4 and all People Supported in need of crush medications. Nursing will monitor this via medication observations x1 a week for 1 month and then on a routine basis to ensure physician's orders are followed during medication administration.</p> <p>In the future, the Qualified Professional will ensure an order is obtained for individuals requiring crushed medication.</p> <p>By: 4/19/20</p>	

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

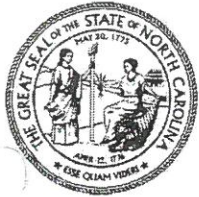
PRINTED: 02/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 WESTRIDGE ROAD GREENSBORO, NC 27405
--	--

(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 4 (QIDP) confirmed client #4 is on a pureed diet consistency. Further interview with the facility nurse confirmed all of client #4's by mouth medications should indicate to crush.	W 369		
-------	--	-------	--	--



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

February 26, 2020

Ms. Sheila Shaw, Administrator
RHA Health Services LLC
1508 Gatewood Ave.
Greensboro, NC 27405

DHSR - Mental Health

MAR 10 2020

Lic. & Cert. Section

Re: Recertification Completed February 20, 2020
Westridge 1609 Westridge Rd. Greensboro, NC 27410
Provider Number 34G160
MHL# 041-076
E-mail Address: sshaw@rhanet.org

Dear Ms. Shaw:

Thank you for the cooperation and courtesy extended during the recertification survey completed February 20, 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

- 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 April 19, 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.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

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.***

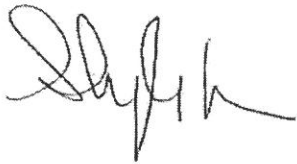
Send the original completed form to our office at the following address within 10 days of receipt of this letter.

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 me at (828) 750-2702.

Sincerely,



Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org
DHSR_Letters@sandhillscenter.org