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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An onsite recertification and complaint survey was completed on October 20, 2020 for Intakes #NC00168748, NC00168372 and NC00168206. The complaint Intakes were unsubstantiated. Deficiencies were cited however as a result of the recertification survey.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to implement written policies and procedures that prohibit neglect of clients (W149). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews with staff, the facility neglected to put measures in place that would prevent 1 of 3 audit clients (#3) from falling out of his wheelchair and bed which put him at risk for repeated injures.	W 149		

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

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W 149	Continued From page 1 The findings include: The interdisciplinary team failed to put measures in place to prevent further falls for client #3 which resulted in additional injuries. During observations in the facility on 10/19/20 at 10:05am client #3 was in the living room, sitting in his wheelchair, wearing a sling on his right arm. Immediate interview on 10/19/20 with staff A revealed client #3 had fallen out of his wheelchair several weeks ago and chipped a bone in his shoulder and was recovering from that injury. Throughout afternoon and evening observations on 10/19/20 in the facility for 120 minutes (4:35pm-6:35pm) client #3 did not wear his sling and transferred himself to the living room couch before staff could assist him. For example: Observations on 10/19/20 in the facility at 4:35pm revealed client #3 was sitting in his wheelchair without his sling on his right arm. Client #3 was also not wearing his seatbelt in his wheelchair. At 4:35pm, he stood up unassisted before direct care staff could get to him and transferred to the couch in the living room. Direct Care staff did not redirect client #3 to put on his sling or fasten his seatbelt. At 5:56pm, staff A asked client #3 if he wanted to come to the dining room to eat supper. Client #3 declined and continued to watch television in the living room, sitting on the couch. Throughout the remainder of observations in the facility until 6:30pm, client #3 remained sitting on the couch without his sling on his right arm. Staff A and Staff C asked client #3 several times if he would like to eat supper, but he declined and continued to watch television until the surveyor departed at 6:35pm.	W 149		

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W 149	Continued From page 2 During observations in the facility on 10/20/20 at 6:15am client #3 was sitting on the side of his bed being assisted with his socks and shoes by staff E. He was not wearing his sling on his right arm. Staff E assisted him to his wheelchair and gave him several verbal cues to fasten his seatbelt on his wheelchair. Staff E explained to him that the seatbelt was to keep him safe and to prevent him from falling out of his wheelchair and getting injured. Staff did not redirect client #3 to put his sling on his right arm. Client #3 complied with staff E's request and fastened his wheelchair belt. He ate breakfast at 6:37am and scooped cereal and milk with a spoon using his right hand at the dining room table. Interview with staff E on 10/20/20 revealed audit client #3 can be very non-compliant with fastening his seatbelt in his wheelchair and allowing staff to put a mat beside beside his bed at night. He demonstrated that the mat is kept outside client #3's bedroom along the wall in the hallway because he will not allow staff to put it in his room. Staff E stated they had been instructed to wait until client #3 goes to sleep and then to put the mat beside his bed to prevent injuries if he falls out of bed during the night. Staff E stated that client #3 is checked every 15 minutes during the night. Continued observations on 10/20/20 at 7:55am revealed client #3 went to the medication room. Client #3 was leaning significantly to the right and had to be repositioned in his wheelchair. Client #3 was not wearing his sling on his right arm. Staff B reminded him to go to his bedroom and get his sling . Staff B then assisted him with getting his sling positioned on his right arm. At the	W 149		

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medication room door, client #3 told staff B that his arm hurt. During the medication pass, staff B contacted the Nurse to inform her audit client #3 had dropped a Colace on the floor during medication administration, however he was not given medication for pain during the medication administration pass.

Review of nursing notes for client #3 revealed the following:
8/17/20: Seen at local hospital for generalized weakness, fall and for knee pain.
8/26/20: seen at local hospital for right clavicle fracture (seizure and feel out of wheelchair)
9/9/20: Received call from staff B client fell in bathroom floor on right side. Red bruising noted on right outer arm. No other injuries noted. He is currently wearing a sling for a right clavicle injury.
9/15/20: On 9/5/20 client #3 had follow up with local orthopedic clinic where he was seen at local hospital on 8/26/20 for treatment of right clavicle fracture. At orthopedic visit, discussed the importance of, "keeping the right arm immobilized".
9/15/20: Saw primary care provider for follow up from Emergency Department visit on 8/26/20 and seizures. Primary care provider ordered an EEG and CT scan of client #3's brain to address recent seizure activity. Spoke with Nurse, no acute intracranial pathology.
9/15/20 at 10:30am Received call yesterday from staff B that at 10am client was in his bedroom, yelled and staff entered his bedroom and found client #3 on the floor. Staff witnessed seizure for a few seconds.
9/15/20: Reported to Nurse that client #3's Mother contacted the residential manager and was concerned about bleeding from his eye and that this may be seizure related. Nurse contacted

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Neurology office and was instructed to take client #3 to the local emergency department at the hospital for evaluation. There were no visible signs of injury and client #3 complained that his head hurt. Transported to hospital for evaluation.
9/23/20: Client reported to staff he fell out of wheelchair.
9/28/20: Client #3 fell out of his bed. His mat was not next to his bed.
10/6/20: Fell out wheelchair while in the bathroom. Staff was present and turned around to get his caddy and fell forward out of wheelchair onto the floor.

Review of incident reports for client #3 revealed the following:
-9/23/20 at 12:22pm: "Staff was assisting a client with his food when I heard client #3 yell. I turned around and client #3 was on the floor crying. Assisted him off the floor and completed a body check. Body check revealed no bruises after fall" Preventative measures taken: "Continue to Monitor".
-9/24/20 at 6:30pm: Just passed client #3 in his bedroom and he holding up a piece of paper, went to get gloves and heard a boom. I went to his room and he was on the floor. We helped him up off the floor. He said he was trying to get into his chair. Preventative measures: "Continue to monitor."
-9/28/20 at 4:45am: Client #3 rolled out of bed and hit his eye on his wheelchair. Both staff members assisted him back into the bed and applied first aid. Program manager was notified. Preventative measures taken: "Meeting with the team and the parents."
10/1/20 at 1:30pm: Client #3 fell out of wheelchair in the hallway while he was on his way to the bathroom. We assisted him into his wheelchair

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and checked him for injuries. No injuries were noted. Notified the qualified intellectual disabilities professional. Preventative Measures: "Continue to instruct staff on the importance of client #3 sitting back in his wheelchair."

Interview on 10/20/20 with the facility nurse revealed client #3 has a seizure disorder that is not well controlled despite close attention to his medication regimen and many visits with his Neurology provider. Further interview with the Nurse revealed client #3 has pain medication that can be given if client #3 exhibits pain. She stated she has instructed staff to contact her if he has discomfort so the pain medication can be administered. The Nurse stated client #3 should keep his right arm immobilized in a sling except when he is participating in physical therapy.

Additional interview on 10/20/20 with the Nurse revealed client #3 has experienced continued falls from his wheelchair and from his bed. She emphasized that staff have been told repeatedly to ensure that his wheelchair belt is fastened and that his mat is next to his bed at night. She also stated that a bar has been installed on the wall in his bedroom next to his bed to assist him with transfers.

Continued interviews with the facility Nurse revealed she had been contacted about another recent fall by the residence manager on 10/15/20 indicating that client #3 fell out of his bed onto the floor and that his mat was not next to his bed. She stated the text she received from the residence manager stated client #3 had a bruise in the middle of his back as a result of the fall.

Review on 10/19/20 of client #3's record revealed

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he has a diagnosis of: Schizophrenia, Moderate Intellectual Disabilities, a Seizure disorder and Expressive Aphasia. Review of his individual program plan (IPP) dated 9/25/20 revealed he requires assistance with toileting and most of his daily living skills. Additional review revealed he uses a wheelchair for mobility and needs to be reminded to fasten his seatbelt. Further review revealed he received a new wheelchair in June 2020. Additional review revealed falls have increased since he will not comply with sitting back in his wheelchair.

Review on 10/19/20 of an addendum to client #3's IPP dated 9/8/20 revealed due to client #3's declining health and supports client #3 requires more assistance with personal hygiene and daily support staff are to provide any physical assistance needed for bathing, getting dressed and other tasks. Client #3 requires 1:1 assistance for any transfers as needed for his safety.

Review on 10/19/20 of client #3's behavior support program (BSP) dated 12/16/19 revealed he has target behaviors of aggression, spitting, property destruction, severe disruption, AWOL, and failure to make responsible choices. Further review revealed he ingests Lamictal, Valproic Acid, Quetapine and Lorazepam for behavior support. Exclusionary time out is listed in his BSP for aggression. Interventions include: Reinforce client #3 with verbal praise when he complies with requests, he enjoys looking at books with pictures. Staff should avoid getting into power struggles with client #3. When client #3 becomes upset, converse with him about preferred topics. Staff should also encourage client #3 to ask for help." Staff should always be aware of his whereabouts.

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W 149	Continued From page 7 Interview on 10/20/20 with the qualified intellectual disabilities professional (QIDP) revealed client #3 continues to have many falls from his wheelchair and from his bed. She stated despite staff being asked to encourage him to wear his seatbelt in his wheelchair, wear his sling on his right arm and the bar that has been installed on the wall in his bedroom, he has continued to fall out of his wheelchair and out of bed. The QIDP stated client #3 is very non-compliant about wearing his seatbelt in his wheelchair and also does not want the mat next to his bed at night. She confirmed there had not been updated changes in staffing nor has there has been significant changes in client #3's IPP or BSP. Additional interview confirmed the team has not considered any additional use of assistive/adaptive devices to prevent injuries despite the fact client #3 has fallen 8 times since August 26, 2020 when he fractured his clavicle. Record review and interviews substantiate client #3 had numerous falls out of his wheelchair and his bed which resulted in him fracturing his clavicle on 8/26/20. Despite medical follow up and the installation of a bar on his wall in his room, he subsequently had nine additional falls, several which resulted in additional injuries. As a result, facility management neglected to ensure his mat was placed beside his bed consistently, failed to ensure he wore his sling consistently, failed to ensure his seatbelt was fastened consistently in his wheelchair as well as consider other program measures to ensure client #3 was protected from additional injuries. All of these failures resulted in the neglect of client #3. Review of the facility's policy on neglect revealed,	W 149		

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W 149	Continued From page 8 "Neglect is any situation in which the caretaker does not provide care or services which in turn affect mental or physical health, safety, or well-being of a person. Neglect further refers to the failure of the caretaker to act spontaneously in any situation which might adversely affect the health, safety, or well-being of a person. Examples might include, but are not limited to the following: Inadequate supervision by or failure of staff to control the situation such as failing to help a client who has fallen, leaving clients unattended while assigned to be with them, allowing clients to roam when they are scheduled for activities; failing to help staff who is in the process of intervening with a client and requesting help; failing to intervene in a situation in order to prevent possible harm or injury to the client or other clients.."	W 149		
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 observation, record reviews and interviews, the facility failed to assure a pattern of interactions supported the individual program plans (IPP) in the areas of assisting with transfers when ambulating. This affected 1 of 3 audit	W 249		

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clients (#3). The findings include:

A. Staff failed to follow instructions regarding assisting client #3 with transfers from wheelchair to chairs or his bed.

During afternoon and evening observations on 10/19/20 in the facility for 120 minutes (4:35pm-6:35pm) client #3 did not wear his sling and transferred himself to the living room couch before staff could assist him. For example: Observations on 10/19/20 in the facility at 4:35pm revealed client #3 was sitting in his wheelchair without his sling on his right arm. Staff did not verbally cue client #3 to put on his sling or fasten his seatbelt. Client #3 was also not wearing his seatbelt in his wheelchair. At 4:35pm, he stood up unassisted before direct care staff could get to him and transferred to the couch in the living room.

Review on 10/19/20 of an addendum to client #3's IPP dated 9/8/20 revealed due to client #3's declining health and supports client #3 requires more assistance with personal hygiene and daily support staff are to provide any physical assistance needed for bathing, getting dressed and other tasks. Client #3 requires 1:1 assistance for any transfers as needed for his safety.

Interview on 10/20/20 with the qualified intellectual disabilities professional (QIDP) confirmed direct care staff should assist client #3 with any transfers to prevent injuries.

B. Staff failed to ensure a mat was placed next to client #3's bed to prevent possible injuries from falls.

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W 249	Continued From page 10 Interview on 10/20/20 with the facility nurse revealed client #3 has a seizure disorder that is not well controlled, despite close attention to his medication regimen and many visits with his Neurology provider. She stated he has continued falls from his wheelchair and from his bed. She emphasized that staff have been told repeatedly to ensure that his wheelchair belt is fastened and that his mat is next to his bed at night. She stated she was contacted about another recent fall by the residence manager on 10/15/20 indicating that client #3 fell out of his bed onto the floor and that his mat was not next to his bed. She stated the text she received from the residence manager stated client #3 had a bruise in the middle of his back as a result of the fall. Interview on 10/20/20 with the QIDP confirmed she has asked staff repeatedly to put client #3's mat next to his bed at night as he has a seizure disorder and is at risk for injuries if he falls out of bed.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the team failed to collect data as prescribed for 1 of 3 clients (#6) in order to accurately assess client progress and status. The finding is:	W 252		

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W 252	Continued From page 11 Staff failed to collect data for client #6's training programs. A. Review on 10/19/20 of client #6's individual program plan (IPP) dated 9/10/19 revealed the following programs: Will prepare side dish for supper with 100% independence for 8 consecutive review periods, Will follow laundry routine with 100% independence, follow money management routine and perform oral hygiene tasks. Interview on 10/19/20 with the qualified intellectual disabilities professional (QIDP) confirmed client #6 had not been able to carry out her money management objective purchasing in the community due to the current COVID-19 pandemic. Review of the data for these objectives revealed the following: a) will prepare side dish for supper August 2020: 18 minuses September 2020: 11 minuses October : trained 7 times b) Will follow laundry routine July 2020: 21 minuses August 2020: 15 minuses September 2020: 11 minuses October 2020: 13 minuses c) Will perform oral hygiene tasks August 2020: trained 12 times September 2020: trained 6 times October:2020 no data Interview on 10/20/20 with the QIDP revealed she	W 252		

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W 252	Continued From page 12 was not certain why direct care staff were recorded minuses for client #6's training. She stated staff should be recording client #6's participating in these goals every week. When asked who was to monitor data for objectives, she stated it was the responsibility of the residence manager to check the data weekly and it was her responsibility as the QIDP to train staff and collect the data to record client #6's progress in her notes.	W 252		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the individual program plan (IPP) was reviewed and revised as necessary. This affected 1 of 3 audit clients (#3). The findings are: The qualified intellectual disabilities professional (QIDP) failed to revise client #3's written training programs after he fractured his right clavicle on 8/26/20. Review on 10/19/20 of client #3's individual program plan (IPP) dated 9/25/20 revealed he had the following written training programs: a) Will exercise utilizing his walker for minutes to	W 257		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 257	Continued From page 13 increase mobility and improve ambulation. b) Will improve independent living skills by following a laundry schedule with verbal prompts for 12 consecutive months. c) Will wash his upper body for 90 consecutive days. Review on 10/19/20 of an addendum to client #3's IPP dated 9/8/20 revealed due to client #3's declining health and supports client #3 requires more assistance with personal hygiene and daily support staff are to provide any physical assistance needed for bathing, getting dressed and other tasks. Client #3 requires 1:1 assistance for any transfers as needed for his safety. Interview with the QIDP on 10/20/20 confirmed client #3 fell out of his wheelchair during a seizure on 8/26/20 and fractured his right clavicle. Further interview revealed he is to keep his right arm immobilized in a sling except for when he is participating in physical therapy. Additional interview revealed that his written training programs were not modified at his IPP meeting on 9/25/20.	W 257		