| 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 _____ | R 03/29/2021 |

| 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 |
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| W 224 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(v)<br><br>The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to ensure the Comprehensive Functional Assessment (CFA) for client #4 included an assessment of his medication administration skills. This affected 1 of 3 audit clients. The finding is:<br><br>During observations of medication administration in the home on 3/29/21 at 7:29am, client #4 was prompted to the medication room for his morning medications. The medication technician (Staff D) performed all necessary tasks while client #4 only swallowed his pills.<br><br>Interview with Staff D revealed client #4 will sometimes assist with medication administration tasks but will often refuse.<br><br>Review of client #4's Individual Program Plan (IPP) dated 11/5/20 revealed the client "Cooperates with medication administration". Additional review of the record did not include an assessment of the client's medication administration skills.<br><br>Interview with the Home Supervisor did not indicate an assessment had been completed. | W 224 | W 224<br><br>The facility will ensure a comprehensive functional assessment (CFA) is completed on all individuals. QP will coordinate with the team and facilitate the process of completing the CFA.<br><br>For client #4 the habilitation specialist will complete an Adaptive Behavior Inventory to develop goals to assist individual in reaching his highest level of functioning with medication administration participation. Habilitation Specialist will in service all staff on goal and documentation. Habilitation Specialist will monitor weekly, Group Home Manager will monitor weekly and QP will monitor monthly. | 5/28/21 |
| {W 263} | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii) | {W 263} | | |

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

Barbara Williams | Clinical Supervisor | 4/9/2021

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 263} | Continued From page 1<br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the restrictive Behavior Support Plans (BSP) for 1 of 3 audit clients (#6) included written informed consent from the guardian. The finding is:<br><br>Client #6's BSP did not include a currrent consent from his guardian.<br><br>Review on 3/29/21 of client #6's record revealed a restrictive BSP dated 11/28/20 to exhibit 1 or fewer challenging behaviors of for 11 consecutive months. Review of the plan also identified the use of Risperdal, Depakote, Keppra and Valium to address behaviors. Additional review of the record indicated no current written informed consent was available for the plan.<br><br>Interview on 3/29/21 with the Home Superivor confirmed no current written informed consent for client #6's BSP had been obtained from the guardian. | {W 263} | W 263<br><br>The facility will ensue that a written informed consent from all legal guardians is obtained for all clients with a Behavior Support Plan.<br><br>QP will mail copy to guardian to sign, will contact via telephone to inform of mailing and provide feedback to guardian and will arrange to meet guardian to obtain any or all consent form for client treatment. QP will monitor monthly and as needed. | 5/28/21 |
| W 340 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(i)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. | W 340 | | |

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| W 340 | Continued From page 2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to follow and implement the facility's current COVID-19 preventative procedures and visitor screening process. The findings are:<br><br>A. Upon arrival to the home on 3/29/21 at 6:28am, Staff A answered the door without wearing a face mask. Upon entry into the home, two additional staff (Staff B and Staff C) were not observed to be wearing face masks. All three staff continued to perform various tasks in the home and interact with clients without a mask or face covering. Approximately 45 minutes later, all three staff were then observed wearing face masks.<br><br>Interview with Staff B revealed he had gotten busy and forgot to put on a mask. The staff indicated they are required to wear a face mask when working in the home.<br><br>Review of the facilty's Active Management Procedures - Potential Exposure (updated 2/19/21) revealed, "Face masks should already be on all staff."<br><br>Interview with the Home Supervisor confirmed all staff working in the home should be wearing face masks on all shifts.<br><br>B. Upon arrival to the home on 3/29/21 at 6:28am, the surveyor's temperature was not taken and no COVID-19 screening questions were asked. At 7:25am, nearly an hour after | W 340 | W 340<br><br>The facility will ensure that nursing staff and interdisciplinary team members ensure that appropriate protective and preventative health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. | 5/28/21 |

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| W 340 | Continued From page 3<br>arriving, a management staff arrived at the home and took the surveyor's temperature and asked several COVID-19 screening questions.<br><br>Review of the facility's COVID-19 Alert Procedures - Residential (updated 3/15/20) revealed, "...all visitors should be screened prior to entry with the following questions:<br>* Do you currently have signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat?<br>* In the last 14 days, have you had contact with any of the following:<br>* Someone with a confirmed or presumed case of COVID-19?<br>* Someone under investigation for COVID-19?<br>* Someone with a respiratory illness?<br>* Someone who has been asked to quarantine themselves?<br>* Do you reside in a community where community-based spread of COVID-19 is occurring?"<br><br>Interview with the Home Supervisor confirmed visitors to the home should be screened with a temperature check and should be asked the screening questions indicated in the facility's COVID-19 procedures. | W 340 | The nursing staff will in-service, train and demonstrate to all staff the appropriate usage of PPE. The staff will also be trained through Relias training on appropriate usage of PPE. Staff will be in serviced on facility COVID 19 phases and precautions to be used in the homes and with clients, and correct documentation with COVID guidelines. Manager will monitor daily, Nursing will monitor weekly and QP will monitor monthly. | |
| W 418 | CLIENT BEDROOMS<br>CFR(s): 483.470(b)(4)(ii)<br><br>The facility must provide each client with a clean, comfortable mattress.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interviews, the facility | W 418 | W418<br><br>The facility will provide all clients with a clean comfortable mattress. | 5/28/21 |

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| W 418 | Continued From page 4<br>failed to ensure client #5 had a clean, comfortable mattress. This affected 1 of 3 audit clients. The finding is:<br><br>During observations in the home on 3/29/21, client #5's mattress did not have a protective covering and the mattress was noted to have a large dark brown stain covering a significant area of the bed. The mattress was covered in feces and urine which could be smelled throughout the back hall of the home.<br><br>Interview with Staff A revealed client #4 frequently smears feces and urine at night.<br><br>Interview with the Home Supervisor indicated client #4's mattress did have a plastic cover but he had torn it off. Additional interview confirmed he was in need of a new mattress. | W 418 | The Group Home Manager will order client #5 a new mattress. Program Manager will monitor and assess client and home furniture weekly for any damages. Group Home Manager will put in a work order for any damaged items for replacement when noticed or reported by staff. QP will monitor monthly. | |

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

March 31, 2021

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

Re: Follow-up Survey Completed March 29, 2021
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 follow-up survey completed March 29, 2021.

As a result of the follow-up survey, it was determined that all of the cited deficiencies have not been corrected and additional non-compliance was found, which is reflected on the enclosed CMS-2567

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 May 28, 2021.

**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 Wilma Worsley-Diggs at 919-612-5520.

Sincerely,

Wilma Worsley-Diggs

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

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSRreports@eastpointe.net
File