STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
			A. Boilbino		
		MHL029-125	B. WING		C <b>05/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STATE	= ZIP CODE	
NAME OF I	NOVIDEN ON SOLI LIEN		, ,	L, ZII GODE	
RIDGEWO	OOD		EWOOD DRIVE ON, NC 27292		
(VA) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 000	000 INITIAL COMMENTS		V 000		
	5/24/21. The complain (Intake #NC00176428 This facility is licensed category: 10A NCAC	al survey was completed on nt was unsubstantiated. B). Deficiencies were cited. d for the following service 27G .5600C Supervised Developmental Disabilities.			
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108		
	V 108  27G .0202 (F-I) Personnel Requirements  10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		MHL029-125	B. WING		C <b>05/24/2021</b>
NAME OF D			DEGG OITY OTA	TF 710 000F	1 03/24/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA WOOD DRIVE	TE, ZIP CODE	
RIDGEWO	OD		WOOD DRIVE N, NC 27292		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 108	Continued From page	÷1	V 108		
	and communicable di clients.	seases of personnel and			
	6 audited staff (Staff # Manager and the Qua				
	-Date of Admission: 6 -Diagnoses: Hyperter disorder; Intellectual I (IDD) - Moderate; dea and morbid obesity	nsion; Schizoaffective Developmental Disorder of mutism; cerebral palsy n 1/27/21 his weight was			
	but can transfer -Risk/Support needs a requires full support fo -Comprehensive func 10/6/20: household at	assessment dated 8/6/2020: or transportation needs tional assessment dated and community needs - level needs to wear seat belt			
	-Date of Admission: 5	Client #2's record revealed: /19/21 derate; Schizoaffective			

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 2 of 21

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			B. WING	D WING		
		MHL029-125	B. WING		05/2	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
			EWOOD DRIVE			
RIDGEWO	OOD					
		LEXINGI	ON, NC 27292			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR L	LOC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIL	DATE
			+	,		
V 108	Continued From page	2	V 108			
	. •					
		e; nicotine dependence;				
	chronic obstructive pu					
		ea; hearing loss; lower back				
	pain; acute bronchitis	; edema, hyperlipidemia and				
	hypothyroidism					
	-Annual physical date	ed 4/20/21 listed his weight				
	as 313 lbs.					
	-Client #2 is ambulate	ory				
		•				
	Review on 5/20/21 of	Client #2's ISP dated				
	10/12/20 revealed:					
		ted 10/13/20: Client #2 is				
	dependent on others					
	transportation	ior air aspects or				
	transportation					
	Poviow on 5/20/21 of	Client #3's record revealed:				
	-Date of Admission: 5					
	-Diagnoses: IDD - Mo					
		pilepsy and ototoxic hearing				
	,	e to medicine damaging the				
	cochlea)					
		d 9/24/20 listed his weight as				
	172 lbs.					
	,_,,					
		Client #3's ISP dated				
	11/10/20 revealed:					
	-Mobility: manual whe	eelchair; uses handrail				
	always for transitionin	ng				
	Review on 5/20/21 of	the House Manager's				
	record revealed:					
	-Hire date: 2/8/21					
	-No documentation of	f training on safely lifting				
	and/or assisting with					
	non-ambulatory indivi					
	,					
	Review on 5/20/21 of	Staff #1's record revealed:				
	-Hire date: 1/26/21					
		f training on safely lifting				
	accamonation of	g on oardly many	1			

Division of Health Service Regulation

and/or assisting with

STATE FORM 6899 LR2V11 If continuation sheet 3 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		
			R WING		С	
		MHL029-125	B. WING		05/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RIDGEWO	OOD		WOOD DRIVE			
			N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 108	Continued From page	3	V 108			
		mbulatory individuals into a				
	Review on 5/20/21 of -Hire date: 10/12/20	Staff #2's record revealed:				
	-No documentation of and/or assisting with t non-ambulatory indivi	_				
	-Hire date: 5/10/21	Staff #3's record revealed:  f training on safely lifting				
	non-ambulatory indivi					
	Review on 5/20/21 of -Hire date: 3/15/21	Staff #4's record revealed:				
		f training on safely lifting				
	and/or assisting with t non-ambulatory indivi	•				
	Review on 5/20/21 of (QP) record revealed: -Hire date: 1/9/18	the Qualified Professional's				
		•				
	Interview on 5/20/21 v	with the House Manager				
	- "I have not been trai	ned in proper lifts and pany. I do whatever needs to				
	be done to get [Client lift training at my othe	#3] into his seat. I have had r job.				
	times to get into the v be safer for [Client #3					
		r had her back injured in a to be careful when she ent #3.				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 4 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			P WING		С
		MHL029-125	B. WING		05/24/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	E, ZIP CODE	
RIDGEWO	OOD		EWOOD DRIVE		
	QUILLEN OT		ON, NC 27292		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 108	Continued From page	<del>2</del> 4	V 108		
	assisting with lifts or t	ent#2] are over 300 lbs. and ransfers is unsafe if you're ng procedures. This could n (the clients) and us			
	-"I have no training in transfer clients. -This is how they did work). I guess I do wh tell me to do (when lo	with Staff #2 revealed: safe procedures to lift or  it when I shadowed (began hat they (staff/co-workers) ading clients into the van)." place both (Client #1 and hem."			
	-"[Client #3] is definite severe limited ability t -I haven't had training at this job. But I know	here for lifts and transfers lifts from my other job."			
	-"I've never loaded ar don't think I've had tra -I do have to get [Clie	with Staff #4 revealed: byone into the van. No, I baining on lifts and transfers. Int #3] and [Client #1] out of shed and dressed (both air/non-ambulatory)."			
	safe transportation ar home.	e assessed for all staff in ad lifting clients in the group on arrangements will be d assessments are			
	NCAC 27G .0208 Clie	ss referenced into 10A ent Services (V115) for a and must be corrected			

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 5 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		
		MHL029-125	B. WING		C <b>05/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
RIDGEWO	)OD	107 RIDGE	WOOD DRIVE		
LEXINGT		LEXINGTO	N, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 112	PLAN  (c) The plan shall be assessment, and in plegally responsible per of admission for client receive services beyond (d) The plan shall incomplete the plan shall incompose the projected date of achieved by provision projected date of achieved by strategies;  (3) staff responsible;  (4) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievemen (6) written consent of responsible party, or a session of the plan shall be asserted to	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude:  I that are anticipated to be a of the service and a devement;  View of the plan at least on with the client or legally r both;  I to no r assessment of	V 112		
	_	iew, interviews and			

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 6 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		MHL029-125	B. WING		05/24	/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RIDGEWO	NOD.	107 RIDGE	WOOD DRIVE			
RIDGEWC	ООБ	LEXINGTO	N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	<del>-</del> 6	V 112			
	-					
	of 3 clients (Client #1 are:	, #2 and #3). The findings				
	Review on 5/19/21 of -Date of Admission: 6	Client #1's record revealed:				
		nsion; Schizoaffective				
		Developmental Disorder				
		af mutism; cerebral palsy				
	and morbid obesity					
		on 1/27/21 his weight was				
	336 pounds (lbs.)					
	-Client #1 is non-amb	•				
	-Admission Assessme	ent: referral from leaf mute, can read lips, in				
		ne, can take a couple of				
	steps.	ne, can take a couple of				
	31060.					
	Review on 5/19/21 of	Client #1's Individual				
	Support Plan (ISP) da					
		ity to carry out activities of				
		communications skills and				
		ndent. Where am I now: His				
	(Client #1) continued	extensive benavioral so still a major issue for				
		e. He becomes aggressive				
	_ =	g yelling, throwing objects				
	l '	physically aggressive daily.				
		utilize Day Supports to				
	increase his ability to	communicate and socialize,				
	_	gh exercise and health				
	-	ase his overall wellbeing				
		increase his involvement in				
	1	hrough organized activities				
	and volunteer opport	unities" assessment dated 8/6/2020:				
		assessment dated 6/6/2020.  It of his own wheelchair and				
	crawl (mobile if on the					
	displaying aggression	· ·				
	-Support needs - requ					
	transportation needs	• •				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 7 of 21

Division of Health Service Regulation

Division	of Health Service Regu	liation			_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MIII 000 405	B. WING		C	
		MHL029-125	D. 11110		05/24/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		107 RIDO	SEWOOD DRIVE			
RIDGEWO	OD		ON, NC 27292			
(X4) ID		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
		_	1///			
V 112	Continued From page	e /	V 112			
	Further review of Clie	ent #1's ISP does not				
	_	on how staff should assist				
	_	g his behaviors when he				
	9 1	at any time when being				
		itments, the Day Program or				
		ed by staff to buckle up. ISP				
	does not document					
		of how staff can assist				
	,	nis dignity and privacy when				
		stance in loading onto the				
	van and unloading.					
	Observation on E/10/	21 at approximately 2/20 pm				
	revealed:	21 at approximately 2:30 pm				
		1/21 at approximately 7:45				
		0/21 at approximately 7:45				
		House Manager and Staff				
		#2 and #3 onto the facility				
	van revealed:	and to the year washes as				
		s self to the van, grabs on				
		e with both hands and pull				
	his self out of his whe					
		nts fall to his mid-thigh area				
	exposing his bare but					
		to hang onto the van with				
	left hand and then att	tempts to pull up his				
	sweatpants.	ra atra arata in cilil ll£				
		veatpants pulled halfway up				
		lifts his right knee onto the				
		nen the left knee and crawls				
	to the back seat of the	= :=:::				
		to buckle up and is not				
	assisted to buckle up					
	D	5 Oli - 11 #0 - 11 - 1				
		Client #2's record revealed:				
	-Date of Admission: 5					
	_	oderate; Schizoaffective				
		e; nicotine dependence;				
	chronic obstructive po					
		nea; hearing loss; lower back				
	pain; acute bronchitis	s; edema; hyperlipidemia and				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 8 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c
		MHL029-125	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
RIDGEWO	OOD		EWOOD DRIVE		
	Т		ON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 112	Continued From page	e 8	V 112		
	hypothyroidism -Annual physical date as 313 lbsClient #2 is ambulate	ed 4/20/21 listed his weight ory			
	10/12/20 revealed:	Client #2's ISP dated			
	-Goal: Live as independent as possible. Requires supervision when cooking, self-help skills and hygiene. Participate in medical appointments -Goal: Obtain meaningful employment. Wants to continue to work at a area restaurant when Covid restrictions are lifted. Duties there include taking trash out and washing vegetables to be cookedGoal: Receive support during and if, a crisis situation occurs. May be a threat to his self or others. Continues to require support from trained staff that can assess the nature of his crisis and determine whether the situation can be stabilized -Risk assessment dated 10/13/20: is dependent on others for all aspects of transportation -Further review of Client #2's ISP does not document strategies on how staff should assist Client #2 in managing his behaviors when he refuses to buckle up when being transported by the facility or be assisted by staff to buckle up.				
	-Date of Admission: 5 -Diagnoses: IDD - Mo Explosive disorder; e loss (hearing loss due cochlea) -Annual physical date as 172 lbsAdmission Assessme facility. Client #3 has				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 9 of 21

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		С
		MHL029-125	B. WING		05/24/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
			, ,	,	
RIDGEWO	OOD		EWOOD DRIVE		
		LEXINGT	ON, NC 27292		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JAIL
				,	
V 112	Continued From page	9	V 112		
	. •				
		Client #3's ISP dated			
	11/10/20 revealed:				
		uch independent daily living			
	skills, with minimal sta				
	=	c skills needed to access the			
		mum independence while			
	•	d supported environment .			
	-Comprehensive fund	tional assessment dated			
	10/6/20 revealed:				
	Mobility: manual whe	elchair; uses handrail always			
	for transitioning				
	-Further review of Clie	ent #3's ISP reveals no			
	goals on safely loading	ng and unloading Client #3			
	via staff transfer and	lifts. Further review fails to			
	reveal an assessmen	t of the safety aspects of			
	staff transfer and lifting	ig client #3 versus the safety			
	of a wheelchair ramp				
	•	3			
	Observation on 5/19/2	21 at approximately 2:30 pm			
	revealed:	7 - 7			
	Observations on 3/20	/21 at approximately 7:45			
		House Manager and Staff			
		#2 and #3 onto the facility			
	van revealed:	,, = a ,, e e aa.e,			
		self to the van, grabs on			
		e with both hands and pull			
	his self out of his whe				
		nts fall to his mid-thigh area			
	exposing his bare but	•			
		to hang onto the van with			
	left hand and then att	<del>-</del>			
	sweatpants.	ompto to pail up Illo			
		eatpants pulled halfway up			
		lifts his right knee onto the			
		nen the left knee and crawls			
	to the back seat of the				
		= :=:::			
	- Client #1 is not told				
	assisted to buckle up	•			
	01 " 5"	VO4 1			
	Observations on 5/19	/21 at approximately 2:30			

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 10 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		LETED
		MHL029-125	B. WING	B. WING		C <b>24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE	1 00.	v
DIDCEWO	NOD.	107 RIDG	EWOOD DRIVE			
RIDGEWO	ООО	LEXINGTO	ON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	e 10	V 112			
	self on the facility var - Client #1 wheels his the vehicle door fram his self out of his wheels are self and to self wheels his the vehicle door fram his self out of his wheels his the vehicle door fram his self out of his wheels his the vehicle door fram his self out of his wheels wheels his the vehicle door fram his self out of his wheels w	s self to the van, grabs onto e with both hands and pull selchair. ring gloves holds onto Client hey do not fall down. Client I a minute and then Client #1 to the floor of the van and onto the back seat, then and begins to crawl to the Staff#1 assists as much as at #1's sweatpants stay up. the back seat of the van. buckle up and is not this seat and behind the the wheelchair is not secured.  If all to the van, grabs on the with both hands and pulls the selchair. The fall to his mid-thigh area attocks. To hang onto the van with his				
	his buttocks and then floor of the van and the to the back seat of the	reatpants pulled halfway up lifts his right knee onto the nen the left knee and crawls e van				
	assisted to buckle up	to buckle up and is not				
	Observations on 3/20	0/21 at approximately 8:00				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 11 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		MHL029-125	B. WING	B. WING		C 5/ <b>24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	ZIP CODE	1 00	/L-1/2021
			EWOOD DRIVE	., 211 0002		
RIDGEWO	OOD		ON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 112	am Client #2 crawls in and knees and goes to assisted to buckle up.  Observation of Client and placed on the van his seat. Client #1's withe floor of the van in.  Observation on 3/20/3 of Client #3 being loa. House Manager and to a client #3 is wheeled the front passenger soor and the seat. Client #3 begins to sappears difficult for Conto the back of the finis left leg. Client #3's stands there.  This process takes a control to the seat. Client wards the seat. Client and steps onto van.  Staff have to push Control to seat as it is difficult for control to the seat. Client wards the seat. Cl	to the van and on his hands to the back seat of the van. It to buckle up nor is he with the van. It to buckle up nor is he with the van the buckle up nor is he with the large of the van on the van on the van on the van by the staff #2 revealed:  If up to the van door behind eat.  If and Staff #2 each take on pit area tand on both feet. This lient #3; he reaches to hold front seat and steps up with the right leg is shaking as he capproximately 4 to 7 minutes of and slide Client #3 in ent #3 pulls his right leg up the van the van the van the van the van both feet.  If up to the van door behind eat.  If and Staff #2 each take on pit area tand on both feet. This lient #3; he reaches to hold the van the va	V 112	DEFICIENCY)		
	and onto his hands at - Client #1 then turns	around so his buttocks are pening and begins to move				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 12 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _	COMPLETED		
					С	
MHL029-125		MHL029-125	B. WING		05/24/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		107 RIDGE	WOOD DRIVE			
RIDGEWO	RIDGEWOOD					
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	e 12	V 112			
	Once near the year	loor Client #1 clowly				
	- Once near the van o	leg and reaches for the				
	ground and then stea					
	•	knee until his foot reaches				
	the ground and slowly					
	•	o always hold onto the seat				
		d hold to keep his balance.				
		nt Client #1 must also keep				
	his sweatpants pulled	up.				
	- Client #1 then sits in					
	- Client #2 then kneels and makes his way to the					
		sit on his buttocks and then				
	slides out until he is o	n his feet.				
		with the House Manager				
	revealed:					
	= =	ke to be helped (assisted				
		ty much can get in the van				
	his self. No, he doesn	it for him because he may				
	_	ou. This is how we were				
		owed other staff (Client #1				
	can become violent w	•				
	doesn't want you to).	<b>g</b>				
		t seem strong enough at				
	times to get into the v	an and a wheelchair lift				
	-	ient #3]. This is how we				
	•	shadowed other staff.				
	- I have not been train					
		pany. I do whatever needs to				
	<u> </u>	#3] into his seat. I have had				
		r job. No, the wheelchair is				
	not secured by anythi					
	- we put [Client #3's] van."	wheelchair in the back of				
		seathalt extensions for				
	[Client #1] or [Client #	seatbelt extensions for				
		·∠ <sub>J</sub> . nt #1's) is folded up and				
		hind the driver seat. That is				
	•	[Client #1] from getting up				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 13 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COIVIPLETED	
		MHL029-125	B. WING		C <b>05/24/2021</b>	
				TE 710 0005	03/24/2021	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA EWOOD DRIVE			
RIDGEWO	OOD		N, NC 27292			
OUR MARY OTATEMENT OF DESIGNATION			ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 112	Continued From page	<del>2</del> 13	V 112			
	and attacking the driv	er."				
	Interview on 5/19/21 or "[Client#3] is loaded You can tell it's uncon literally crawls into the days his knees hurt, or -Once they are all load on't fit or you can't g and client #2) to use to overweight that they of the seat. [Client #1's] could really hurt you if and trying to buckle hen. No way to know what	with Staff #1 revealed: twice a day by two staff. infortable for him. [Client #1] e van and I know there are or he just isn't his self. ded the seatbelts either et either of them (Client #1 the seat belts. They're so cover the seat belt buckle in behaviors are such that he f you started pulling around im yourself. t is the right way (loading the van safely and how to do				
	-"I have no training in transfer clients.  - This is how they did work). I guess I do wh tell me to do (when lo - No, he doesn't like the -It would be safer to pring a lift and load them -"He (Client #1) won't you buckle him in. I'm doesn't buckle up."  -There are no goals to this (manage difficult three clients).  Interview on 5/21/21 three client #1's behavior and there is nothing it address Client #1's be-Client #2's plan does	blace both (Client #1 and #3) buckle up and he won't let a not sure why [Client #2] buckle up and he won't let a not sure why [Client #2] bucknow what or how to do behaviors and load the				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 14 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		С	
		MHL029-125	B. WING		05/24/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RIDGEWO	OOD		WOOD DRIVE N, NC 27292			
	OUR MARK OF		1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	e 14	V 112			
	recent assessment as be placed in and van This deficiency is cro- NCAC 27G .0208 Clie	reviewed and there is no sto the best way for him to and transported.  ss referenced into 10 A ent Services (V115) for a mand must be corrected				
V 115	27G .0208 Client Ser	vices	V 115			
	10A NCAC 27G .0208 CLIENT SERVICES  (a) Facilities that provide activities for clients shall assure that:  (1) space and supervision is provided to ensure the safety and welfare of the clients;  (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and  (3) clients participate in planning or determining activities.  (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule.  (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious.  (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment.  (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.					

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 15 of 21

Division of Health Service Regulation

MHL029-125  MHL029	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD BRIVE LEXINGTON, NC 27322    MAI   D	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  107 RIDDEWOOD DRIVE LEXINGTON, NC 27322    MAJ   ID   PREPIX   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION SHOULD BE   PRECLATION OF LOST DESTINATION			MHI 029-125	B. WING		_	
Note   Description   Summary Statement or Deficiencies   Description	NAME OF P	ROVIDER OR SUPPLIER		DRESS CITY STA	TE ZIP CODE	1 03/2	<del>-1</del> /2021
Continued From page 15   DePrice Continued From page 15   DePrice Continued From page 15   DePrice Continued From page 15   V 115	NAME OF T	TOVIDER OR SOLT EIER					
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  V 115  Continued From page 15  V 115  This Rule is not met as evidenced by: Based on records review, interviews and observations the facility failed to ensure safety needs of the clients and failed to ensure state or records review interviews and observations the facility failed to ensure state or records review interviews and observations the facility failed to ensure safety needs of the clients and failed to ensure the vehicle was equipped with adaptive equipment for 3 of 3 clients (Client #1, #2 and #3). The findings are:  Cross Reference: 10 A NCAC 27G .0202 Personnel Requirements (V108). Based on records review and interviews the facility failed to ensure that 6 of 6 audited staff (Staff #1, #2, #3, #4, Home Manager and Qualified Professional (QP)) were trained to meet the needs of clients served.  Cross Reference: 10 A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on records review, interviews and observations the facility failed to ensure strategies were developed and implemented to meet the needs of the clients served affecting 3 of 3 clients (Client #1, #2 and #3).  Observation on 5/19/21 at 2:30 pm of the facility van used for transporting Client #1, Client #2 and client #3 revealed:  - Van is a standard six passenger van - Can seat three passengers in the back row - Can seat three passengers in the middle row. One/half of the middle row seat is removable and was removed from van.	RIDGEWO	OOD					
This Rule is not met as evidenced by: Based on records review, interviews and observations the facility failed to ensure safety needs of the clients and failed to ensure the vehicle was equipped with adaptive equipment for 3 of 3 clients (Client #1, #2 and #3). The findings are:  Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on records review and interviews the facility failed to ensure that 6 of 6 audited staff (Staff #1, #2, #3, #4, Home Manager and Qualified Professional (QP)) were trained to meet the needs of clients served.  Cross Reference:10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on records review, interviews and observations the facility failed to ensure strategies were developed and implemented to meet the needs of the clients served affecting 3 of 3 clients (Client #1, #2 and #3).  Observation on 5/19/21 at 2:30 pm of the facility van used for transporting Client #1, Client #2 and client #3 revealed: - Van is a standard six passenger van - Can seat three passengers in the back row - Can seat three passengers in the back row - Can seat three passengers in the middle row. One/half of the middle row seat is removable and was removed from van.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETE DATE
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client #3 revealed: - Van is a standard six passenger van - Can seat three passengers in the back row - Can seat three passengers in the middle row. One/half of the middle row seat is removable and was removed from van.		Based on records revobservations the facil needs of the clients a vehicle was equipped 3 of 3 clients (Client # are:  Cross Reference: 10/Personnel Requiremerecords review and in ensure that 6 of 6 aud #4, Home Manager a (QP)) were trained to served.  Cross Reference:10/A Assessment and Treaservice Plan (V112). interviews and observensure strategies were implemented to meet served affecting 3 of 3 #3).	view, interviews and ity failed to ensure safety and failed to ensure the with adaptive equipment for \$\frac{1}{2}\tau_1\tau_2\tau_2\tau_1\tau_2\tau_2\tau_1\tau_2\tau_2\tau_2\tau_1\tau_2\tau_2\tau_2\tau_2\tau_1\tau_2\tau_2\tau_2\tau_2\tau_2\tau_2\tau_2\tau_1\tau_2				
- Seats a driver and one front passenger - Doors slide on the right and left sides of van		client #3 revealed: - Van is a standard six - Can seat three pass - Can seat three pass One/half of the middle was removed from va - Seats a driver and of	x passenger van sengers in the back row sengers in the middle row. e row seat is removable and an. one front passenger				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 16 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL029-125		B. WING		C <b>05/24/2021</b>	
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZID CODE	1 03/24/2021	
NAIVIE OF PI	ROVIDER OR SUPPLIER			TE, ZIP GODE		
RIDGEWO	OOD		WOOD DRIVE			
			N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 115	Continued From page	e 16	V 115			
	- Van is not equipped with a wheelchair lift/ramp and not equipped for locking in wheelchairs					
	Interview on 5/21/21					
	Professional revealed	t: ke to be assisted or bumped				
		air and can become pretty				
		ens. So, he has been				
	allowed to enter the van on his own (crawls in on his hands and knees).  - I'm not sure why staff are not buckling in the					
		#2). This is unsafe and will				
		ately. If seat belt extensions				
	were needed, I was not made aware of it by staff."					
	<ul> <li>The Director is awar equipped van.</li> </ul>	re the van is not a handicap				
		/21 and written by the				
	Qualified Professiona					
		on will the facility take to				
		he consumers in your care? ill wear seatbelts when the				
		nd wheelchairs will be stored				
		(not in the passenger area).				
		rained on using the 2 person				
	assist method for tran					
	3. Additional OT (Oc					
	evaluations will be so	-				
		dations are needed related				
	_	d out of the vehicle or safely				
	transporting.	will be amended to address				
		hat the seatbelt is being				
	properly worn and the transported safely.					
	•	o make sure the above				
	happens.	a.c care the above				
		ctor will ensure that all staff				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 17 of 21

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
MHL029-125			B. WING		05/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RIDGEWO	OD	107 RIDGI	EWOOD DRIVE			
		LEXINGTO	ON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 115	Continued From page	e 17	V 115			
	sign a memo detailing transporting individual. The memo will includ seatbelts must be wo is moving. It will also be used when all resi to allow for the space back of the van (away Wheelchairs will be truntil maintenance sta alternate way to safel transporting. The Prodesignee, will monitor months to ensure that followed.  2. All staff will watch to properly perform 2 will be required to cord, 2021 or will be take training has been con Manager, or designee for 3 months to ensurappropriate transfer to 3. The Residential Te evaluations from the individuals to determine equipment is needed individuals. Appointm for June 3rd and June referrals.  4. The Regional Direpsychologist to reque behavior plan to address the seatbelt is being prindividual is being trains.	g immediate protocols for als residing in the program. The the requirement that are at all times when the van explain that 2 vehicles will dents are being transported to locate wheelchairs in the y from passengers). The protocol is being training videos detailing how person transfers. All staff and the schedule until this impleted. The Program e, will monitor at least weekly ethat staff are using the echniques. The primary care doctors of both the if additional adaptive to safely transport the ents have been scheduled e 7th to request the ess strategies to ensure that				
		noses of IDD Moderate; Disorder; epilepsy; ototoxic				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 18 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL029-125	B. WING		C <b>05/24/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
		107 RIDGE	WOOD DRIVE		
RIDGEWO	OOD	LEXINGTO	N, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 115	hearing loss; Schizoaffective Disorder, Bipolar type; nicotine dependence; chronic obstructive pulmonary disease; obstructive sleep apnea; lower back pain; acute bronchitis; edema; hyperlipidemia; hypothyroidism; deaf mutism; cerebral palsy and morbid obesity.  Two of the three clients are non-ambulatory using wheelchairs for mobility. All three clients require assistance with transfers. Client weight ranges are from 176 to 313 lbs. making transfers, assists and mobility challenging. Staff who assist and physically carry clients in and out of the van are not trained in proper lift and transfer techniques. Two clients crawl into and out of a standard, non-handicapped van and the third client is		V 115		
	lifted/assisted by staff then place an unsecu	f into the vehicle seat. Staff ired wheelchair on the floor			
	strategies on transpo	ing, developing goals and rtation safety, safe loading			
	of non-ambulatory clients (Client #1 and #3) into a non-handicapped van and managing difficult behaviors makes these circumstance unsafe for Client #1, #2 and #3. This constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$5000.00 is imposed. If the violation is not corrected within 23 days, an administrative				
		er day will be imposed for s out of compliance beyond			
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736		
	10A NCAC 27G .0303 EXTERIOR REQUIR	EMENTS			
		clean, attractive and orderly kept free from offensive			

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 19 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С	
	MHL029-125		B. WING		05/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
			EWOOD DRIVE			
RIDGEWO	OOD	LEXINGTO	ON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 736	Continued From page odor.	e 19	V 736			
	This Rule is not met as evidenced by: Based on observations and interview the facility failed to maintain the facility in a safe, clean, attractive and orderly manner. The findings are:					
	Observations on 5/19/21 at approximately 3:35 pm of the group home revealed: -Dining area room (front room) air intake duct filter was thick with and completely covered in dust, hair and particlesDining area window revealed numerous cobwebs, dead flies, spiders and dust covering each windowClient bathroom was missing the toilet's water tank cover. The holds for a towel rack and toilet paper rack were still in the wall but missing the rods. Bathroom window was also filled with dead flies, spiders, dust and cobwebsClient #2's bedroom had a large (approximately 3 x 4) hole that had been drywalled but not sanded and painted -Client #3's bedroom revealed the blind broken/torn at one of the four windows and no blind on one of the four windows. All the windows were covered in dust, cobwebs, dead flies and					
	spiders. Client #3 was right dresser drawer. -Front entrance door/	s missing a cover to his top outside glass door was dust s, dead flies and spiders. with the Qualified				

Division of Health Service Regulation

STATE FORM 6899 LR2V11 If continuation sheet 20 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			SURVEY LETED		
			7 50.25			С	
		MHL029-125	B. WING 05/24/2021				
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
RIDGEWO	OOD		EWOOD DRIVE ON, NC 27292				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE	

Division of Health Service Regulation