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## FACSIMILE TRANSMITTAL SHEET

NC Dept of Health &  
TO: Human Services

FROM: Tonia Beckwith  
5/18/2021

COMPANY:

DATE:

FAX NUMBER:

4  
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NOTES/COMMENTS:

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THANK YOU.

May 18,2021

NC Department of Health and Human Services  
1800 Umstead Dr., Williams Building  
Raleigh, NC 27699-2718

Lisa,

Thank you for sending the POC for Pineridge,please find enclosed the POC for Pineridge. We look forward to your follow up, if you have any questions please feel free to contact us. Thank you.

Sincerely,  
Tonya Beckwith, QIDP  
(919)656-3707

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

PRINTED: 02/01/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2021
NAME OF PROVIDER OR SUPPLIER  PINE RIDGE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	{W 000}		6/1/21
W 436	<p>A follow-up survey survey was completed on 1/19/2021 for survey completed 10/20/2020. All deficiencies cited were corrected. A new deficiency was cited and the facility remains out of compliance.</p> <p><b>SPACE AND EQUIPMENT</b> CFR(s): 483.470(g)(2)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all adaptive equipments (right side pillow roll) was provided for 1 of 2 audit clients (#3). The finding is:</p> <p>During observations in the home on 1/19/2021 from 11:30am -12:30pm, client #3 was not provided a comfortable wheelchair. Further observation revealed staff had to support the clients head with hand from the right side as they tried to prepare him for lunch. The client did not consume lunch with the peer due to inability to hold himself into upright position,</p> <p>Interview with staff home manager on 1/19/2021 revealed client #3 was evaluated by physical therapist (PT) and the right side pillow roll was implemented. However, the client has been refusing to use any device that supposed to help</p>	W 436	<p>Facility will ensure that adaptive equipment is provided to meet each client's need as identified by interdisciplinary team.</p> <p>QIDP will schedule a team meeting for client #3 to review the physical therapist recommendations and relates to wheelchair usage for proper body alignment, right side pillow roll. Client refusal to cooperate with equipment needs or devices for support.</p> <p>PP will provide training to staff to provide any strategies of any adaptive equipment use. Such as pillow roll.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Handwritten Signature]*

*[Handwritten Title]*

5/18/2021

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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NAME OF PROVIDER OR SUPPLIER  <b>PINE RIDGE GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>739 ARTHUR MADDOX ROAD SANFORD, NC 27330</b>		
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W 436	<p>Continued From page 1</p> <p>him with alignment/ positioning. She added the staff were trained to transfer the client to the couch if he refuse to use any device that is used to help him sit safely on his seat.</p> <p>Review on 1/19/2021 of client #3's PT evaluation dated 11/20/200 revealed the client should use the right side pillow roll when using the wheelchair for proper body alignment to prevent fall.</p> <p>Interview on 1/19/2021 with the qualified intellectual disabilities professional (QIDP) and program manger revealed the client had an evaluation with the PT and the new devices were implemented however they were not aware of the refusal of the client to comply with the use.</p>	W 436	<p>QIP and Program Manager will do observations in the home to ensure implementation of the IPP use of adaptive equipment.</p>	