STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure sufficient direct care staff were available to manage and supervise 5 of 6 clients in the home (#3, #6, #7, #11 and #12) in accordance with their individual habilitation plan (IHP). The finding is: A. The facility failed to assure sufficient direct care staff were available to manage and supervise clients #3, #6, #7, #11 and #12 in Ridgecrest I. For example: Observation in the group home on 6/30/21 at 6:45 AM revealed one staff on shift, staff D. Continued observation revealed client #10 to exit the home, stand in the middle of the driveway, then dart into the street and into the neighbors driveway. Staff D immediately followed client #10 outside leaving the other 5 clients inside the group home unsupervised. Further observation revealed client #3 to sit in the dining room and client #11 to exit his bedroom and wander the group home looking for staff. Observation at 7:00 AM revealed staff D to yell out to staff E, who pulled up in the driveway, for assistance with getting client #10 back into the home while staff D returned to the group home. Additional observation at 7:05 AM	W 186		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 186	Continued From page 1	W 186		

revealed staff E to enter the group home with client #10.

Interview with staff D on 6/30/21 at 6:45 AM revealed she was the only staff on shift and other staff should arrive by 7:00 AM although she did not know who was scheduled to work as the facility had been short staffed. Continued interview with staff D revealed the ratio in the home was 1 staff to 3 clients. Interview with staff E at 7:00 AM verified she normally works at the day program and was filling in at the home.

Interview with the facility administrator on 6/30/21 verified staff ratio in the group home is 1 staff to 3 clients during awake hours. Continued interview with the facility administrator revealed staff D should have called 911 for support rather than leaving the group home, leaving 5 clients unsupervised.

B. The facility failed to provide sufficient direct support staff to manage and supervise client #12 in Ridgecrest I. The finding is:

Observation in Ridgecrest I on 6/30/21 at 8:10 AM revealed client #12 to walk out the front door of the group home with no knowledge to any staff on shift. Continued observation at 8:12 AM revealed client #12 to walk in the treeline of the woods next to the group home. Further observation at 8:14 AM revealed Staff D to walk to the side door of the group home and call out client #12's name. Subsequent observation revealed staff D to establish and maintain eyesight of client #12.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/30/21 verified staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 186	Continued From page 2 should always be aware of each client's whereabouts.	W 186		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: The facility failed to assure staff training relative to personal hygiene needs of 6 of 6 clients in Ridgecrest I relative to handwashing and toothbrushing. The findings are: A. The facility failed to implement handwashing for 6 of 6 clients. For example: Observation in the group home on 6/29/21 at 4:45 PM - 6:30 PM revealed clients to participate in the dinner meal, clean up, take dishes to the kitchen, participate in outdoor leisure activities, fix beverages and engage in additional leisure/sports activies until 6:30 PM. At not time during observations were clients prompted to wash their hands. Observation in the group home on 6/30/21 at 6:30 AM - 9:10 AM revealed all clients to get up, get dressed, participate in the breakfast meal, clean up, take dishes to the kitchen, participate in medication administration and go outside for leisure activity. Continued observations at 9:10 AM revealed staff E to inform other staff and clients that it was time to get on the van. Further observation revealed all clients and both staff to load the van and leave for an appointment. At no	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 192	Continued From page 3	W 192		

time during observations were clients prompt to wash their hands.

Interview on 6/30/21 with the facility nurse and administrator revealed all clients should be encouraged to wash their hands throughout activity transitions. Continued interview with the facility nurse and administration revealed clients should be prompted to wash their hands before and after meals, the completion of all activities and before accessing drinks or snacks.

B. The facility failed to address health needs relative to oral hygiene for client #6 and #11. For example:

Observation in the group home on 6/30/21 at 6:30 AM - 9:10 AM revealed all clients to get up, get dressed, participate in the breakfast meal, take dishes to the kitchen, participate in medication administration and to go outside for leisure activity. Continued observations at 9:10 AM revealed staff E to inform other staff and clients that it was time to get on the van. Further observation revealed all clients and both staff to load the van and leave the group home. At no time during observations were clients prompted to brush their teeth after breakfast or before leaving the home.

Interview with staff E revealed clients typically brush their teeth after breakfast. Continued interview with staff E revealed it had been a challenging morning and time constraints with trying to get client #11 to a medical appointment had interfered with the morning routine.

Review of records for client #6 on 6/30/21 revealed a dental consult dated 4/20/21. Review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 192	Continued From page 4 of the current dental consult for client #6 revealed the client to have heavy plaque. Recommendations revealed the need to brush longer to get plaque off teeth and floss daily. Review of records for client #11 revealed the last dental consult for the client to be unavailable. Interview on 6/30/21 with facility nurse and administrator revealed all clients should be encouraged to brush their teeth following meals.	W 192		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to assure opportunities for client choice and self-management for 5 of 6 clients (#6, #7, #10, #11 and #12) in Ridgecrest #1 relative to activity choice and community integration. The findings are: A. The facility failed to assure client choice and self-management relative to sitting outside for client #10. For example: Observation in the group home on 6/29/21 at 6:30 PM revealed all six clients and three staff to enter the home following outdoor leisure activities. Continued observation revealed client #10 to return outside and sit in a chair. Further observation revealed staff A to verbally prompt client #10 to go back inside the home. Additional observation revealed Staff A and C to place client #10 into a two-person restrictive carry, with the clients feet off the ground, and to walk the client	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 247	Continued From page 5	W 247		

into the group home. Client #10 was subsequently observed to make loud vocalizations while being carried back into the group home.

Interview with staff A on 6/29/21 revealed it was necessary to bring client #10 back into the group home as all other clients and staff had returned into the group home. Continued interview with staff A revealed client #10 needed to come inside the group home as it would be difficult for him to unwind if he remained outside.

Interview with the facility administrator on 6/30/21 verified client #10 should have the choice to sit outside with staff supervision. Continued interview with administration revealed client #10 should not have been carried into the group home by staff A and C as restrictive techniques should only be implemented when client safety is at risk.

B. The facility failed to assure client choice regarding community integration. For example:

Observation in the group home on 6/30/21 at 6:30 AM - 9:10 AM revealed all clients to participate in the breakfast meal, to take dishes to the kitchen, to participate in medication administration and to go outside for leisure activity. Continued observations at 9:10 AM revealed staff E to inform other staff and clients that it was time to get on the van and ride to client #10's appointment. Further observation revealed all clients and both staff to load the van and leave for client #10's appointment. At no time during observation were clients offered the opportunity to stay home instead of going to client #10's medical appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 247	Continued From page 6 Interview with staff E confirmed client #10 had a scheduled medical appointment and all clients had to go to the appointment to ensure proper ratio of staff to clients. Continued interview with staff E revealed she wanted to make sure client #10 made it to his appointment to prevent rescheduling of the appointment. Interview with the facility administrator revealed there was a staff scheduled to take client #10 to his medical appointment, however there was a sudden schedule change because of staff shortage at another home. The administrator also confirmed clients should have been provided the opportunity for choice and self-management which did not occur.	W 247		
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 observations, record review and interviews, the facility failed to ensure 3 of 12 clients (#7, #8 and #10) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The findings are:	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 7	W 249		

A. The team failed to ensure interventions relative to the behavior support plan (BSP) were implemented as prescribed for client #10 in Ridgecrest I. For example:

Observation in the group home on 6/29/21 at 6:30 PM revealed all six clients and three staff to enter the home following outdoor leisure activities. Continued observation revealed client #10 to return outside and sit in a chair. Further observation revealed staff A to verbally prompt client #10 to go back inside the home. Additional observation revealed Staff A and C to place client #10 into a two-person restrictive carry, with the clients feet off the ground, and to walk the client into the group home. Client #10 was subsequently observed to make loud vocalizations while being carried back into the group home.

Review of records for client #10 revealed a BSP dated 6/8/20. Continued review of the BSP for client #10 revealed identified target behaviors of: property misuse, verbal and physical aggression, cooperation difficulties, tantrums, SIB, food snatching, AWOL, provoking or pestering, and inappropriate sexual behavior. Review of interventions identified in the BSP revealed a restrictive intervention of a therapeutic hold to be used to support client safety.

Interview with facility administration revealed client #10 should not have been carried into the group home by staff A and C as restrictive techniques should only be implemented when client safety is at risk. Continued interview with the facility administrator and clinical staff verified client #10's BSP should have been implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 8 as prescribed with regard to re-direction strategies for client #10. B. The team failed to ensure interventions relative to the behavior support plan (BSP) were implemented with consistency for client #8 in Ridgecrest II. For example: Observation in Ridgecrest II on 6/29/21 at 4:30 PM revealed dinner preparation activity to occur in the kitchen. Continued observation of the kitchen area revealed a padlock to be placed on the refrigerator that was at the time of observation, unlocked to allow access to contents of the refrigerator. Further observation revealed the padlock of the refrigerator to remain unlocked throughout observations that ended after the dinner meal. Observation on 6/30/21 at 7:10 AM revealed staff G to access a set of keys from staff F that were used to unlock the padlock on the refrigerator of the group home. Continued observation revealed morning meal preparation activities to occur in the kitchen with staff G entering and exiting the kitchen at various times to complete activities in the dining room, conduct client care and to monitor clients in other areas of the group home. Further observation revealed the padlock on the refrigerator to remain unlocked throughout all morning observations that concluded at 8:45 AM. It should also be noted client #8 was observed to stand against the dining room wall near the refrigerator while the refrigerator was unlocked. Interview with staff G on 6/30/21 revealed the padlock was recently placed on the group home refrigerator due to food seeking behaviors of	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 9	W 249		

client #8. Continued interview with staff G revealed she was unsure of the guidelines that were to be followed with the padlock as there had not been any training.

Review of records for client #8 on 6/30/21 revealed a BSP dated 10/19/20 with multiple addendums. A review of the BSP for client #8 revealed target behaviors of: agitation (that may lead to disruptive behaviors), AWOL, aggression, property destruction, obsessive compulsive behavior and auditory hallucinations. Review of an IRIS report dated 5/17/21 revealed client #8 was hospitalized due to behavioral issues that included AWOL and food snatching.

Review of BSP addendums for client #8 revealed the addition of food snatching behavior to client #8's BSP and an implemented restriction with the use of a lock on the group home refrigerator and pantry. Subsequent review of records for client #8 revealed no guidelines or staff training relative to the use of the lock on the refrigerator or pantry that was added to client #8's BSP.

Interview with the facility administrator and clinical staff on 6/30/21 verified the lock on the group home refrigerator and pantry had recently been implemented as a result of food snatching behavior of client #8. Continued interview with the facility administrator and clinical staff verified staff should not leave the kitchen unattended with the lock of the refrigerator unlocked. Subsequent interview with the facility administrator and clinical staff verified guidelines had not been developed specific to the use of the lock on the group home pantry or refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 10	W 249		

C. The facility failed to implement a communication objective for client #7 in Ridgecrest I. For example:

Observations in the facility during the 6/29-6/30 survey revealed client #7 to be non-verbal. Continued observation revealed all staff (A,B, C, D and E) to provide verbal prompts and requests to client #7 during dinner time, leisure, and medication administration. No communication tools or devices were observed to be utilized by staff during any survey observation.

Review of client #7's record on 6/30/21 revealed a speech-language evaluation dated 1/4/21. Review of the 1/2021 evaluation revealed a communication goal that client #7 will answer a simple question when shown objects in picture cards, to answer yes or no for 3 questions with 80% accuracy for 3 consecutive review periods. Continued review of the speech evaluation revealed recommendations that included: 1) implementation of the communication goal; 2) client #7 may use the voice output device informally if staff would like to; 3) staff should provide daily social stimulation, use proper language models when interacting with client #7, label objects and action as he is experiencing them, present reasonable and safe choices, and support him to participate in ADLs; 4) acknowledge client #7's subtle communication attempts which may include object retrieval, eye contact, vocalization, body posture, rocking movement, and facial expression.

Further review of client's #7 record indicated a communication program with an implementation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 11 date of 1/4/21. The communication program indicated client #7 will answer a simple question when shown objects in picture cards, to answer yes or no for 3 questions with 80% accuracy for 3 consecutive review periods. Interview with the qualified intellectual disabilities professional (QIDP) on 6/30/21 revealed staff should utilize a push button box that displays pictures to communicate with client #7. Continued interview with the QIDP confirmed staff should be implementing the communication program for client #7 anytime they attempt to engage the client in social interaction. D. The facility failed to implement a privacy objective for client #7 in Ridgecrest I. For example: Observation in the facility on 6/29/21 at 5:14 PM revealed client #7 to enter the restroom and leave the door cracked. Further observation revealed client #7 to sit on the toilet while the door remained partially open. Review of records for client #7 on 6/30/21 revealed a behavior support plan (BSP) dated 10/19/20. Continued review of client #7's BSP indicated a privacy goal in which staff will follow client #7 to the restroom when the client indicates that he is going to make sure that the client is closing the door. Interview with the qualified intellectual disabilities professional (QIDP) on 6/30/21 verified staff are supposed to follow client #7 at all times to the bathroom to ensure he closes the door.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 288	Continued From page 12 BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure techniques used to manage inappropriate behavior for 1 of 12 sampled clients (#10), were not used as a substitute for an active treatment program. The finding is: Observation in the group home on 6/29/21 at 4:45 PM revealed client #10 to sit at the dining table and fix his plate with hand over hand assistance. Continued observation revealed client #10 to begin eating, to take off his shoes and slid them down the middle of the hallway followed by a cup. Further observation revealed staff A to verbally redirect client #10, then state "That's inappropriate, if you do that again you will be removed from the table". Additional observation at 5:10 PM revealed staff B to escort the client using a one person control walk to the living room area. Observation at 6:30 PM revealed all six clients and three staff to enter the group home following outdoor leisure activities. Continued observation revealed client #10 to return outside and to sit in a chair. Further observation revealed staff A to verbally prompt client #10 to go back inside the home. Additional observation revealed Staff A and C to place client #10 into a two-person restrictive carry, with the clients feet off the	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 288	Continued From page 13	W 288		

ground, and to walk the client into the group home. Client #10 was subsequently observed to make loud vocalizations while being carried back into the group home.

Interview with staff A revealed the client could not remain outside because everyone else was inside and it would be difficult to get the client to unwind if he remained outside. Further interview revealed the two person carry was completed because client #10 did not comply with verbal directives to come into the group home. Additional interview with staff A revealed she was not sure whether the restrictive carry was tied to client #10's behavior support plan (BSP).

Review of records for client #10 on 6/30/21 revealed a person-centered plan (PCP) dated 9/1/20. Review of client's PCP revealed a behavior plan for target behaviors of property misuse, verbal and physical aggression, cooperation difficulties, tantrums, SIB, food snatching, AWOL, provoking or pestering, and inappropriate sexual behavior. A review of intervention strategies relative to client #10's target behavior of AWOL revealed if client #10 does not respond immediately to a verbal prompt and places himself in a situation that constitutes an immediate threat to his safety, staff may use a planned restrictive intervention to move the client out of harms way. This includes a limited control walk. Review of intervention strategies listed for all other target behaviors did not include any restrictive intervention technique.

Interview with the facility qualified intellectual disabilities professional (QIDP) revealed clients should not be restricted from the dining table. Continued interview with the QIDP confirmed all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 288	Continued From page 14 interventions should be implemented as prescribed. Further interview verified placing client #10 in a limited control walk or a restrictive carry due to noncompliance was not part of the client's behavior plan and should not have occurred.	W 288		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the system for drug administration failed to assure 2 of 12 sampled clients (#3 and #12) observed during the medication pass were provided teaching related to name, purpose and side effects of medications administered. The findings are: A. The system for drug administration failed to assure client #12 was provided teaching related to the name, purpose or possible side effects of medications received. For example: Observations in the group home on 6/30/21 at 7:25 AM during medication administration revealed client #12 to receive medications that included: Clonazepam 1mg, risperidone 0.5 mg, vesicle 10mg, vitamin D3 2000 unit, lisinopril 5mg, montelukast 10mg and cabergoline 0.5mg. Continued observations revealed client #12 to	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 371	Continued From page 15	W 371		

take medications followed by a cup of water. At no point during observations did staff B provide client #12 with teaching related to the name, purpose or possible side effects of medications administered.

Review of the medical record for client #12 on 6/30/21 revealed a person-centered plan (PCP) dated 10/4/20. Continued review of the PCP revealed with regard to medication administration, client #12 will assist with collecting waste and will dispose of trash. Continued review revealed client #12 will also punch pills out of the pack with assistance.

Interview with the facility nurse on 6/30/21 verified client #12 should have been provided education during his medication pass with the identification of the name of the medication, purpose and side effects.

B. The system for drug administration failed to assure client #3 was provided teaching related to the name, purpose or possible side effects of medications received. For example:

Observations in the group home on 6/30/21 at 7:55 AM during the medication administration revealed client #3 to enter the medication closet, sit in a chair and receive medications. Continued observations revealed client #3 to take medications followed by a cup of water. At no point during observations did staff B provide client #3 with teaching related to the name, purpose or possible side effects of medications administered.

Interview with the facility nurse on 6/30/21 verified client #3 should have been provided education during his medication pass with the identification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 371	Continued From page 16 of the name of the medication, purpose and side effects. Continued interview with the nurse confirmed staff are trained to provide education to all clients when administering medications as part of client rights during medication administration.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure all drugs and biological's were kept lock except when being prepared for administration in Ridgecrest II. The finding is: Observation in Ridgecrest II on 6/30/21 at 7:45 AM revealed staff F to leave the medication room and walk to the bedroom of client #1. Continued observation revealed staff F to leave the medication room door open with the medication cart unlocked inside the medication room. Subsequent observation revealed the keys to the medication cart to be left on top of the unlocked and unattended medication cart. Observation at 7:52 AM revealed staff F to return to the medication room and properly secure medications in the medication cart. Interview with staff F on 6/30/21 revealed she should not have left the medication room door open and unlocked. Continued interview with staff F revealed medications should be kept locked and she should not have left medications unlocked and unattended. Interview with the	W 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 382	Continued From page 17 facility nurse further verified all medications should be kept locked and secured, the medication room key should always remain with the staff responsible for administering medications and the medication room door should remain locked when not in use.	W 382		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide sufficient space for ambulation for 1 of 6 clients (#3) in Ridgecrest I. The finding is: Observation in the group home on 6/30/21 at 6:45 AM revealed exercise equipment to be in the hallway of the group home. Continued observation at 6:50 AM revealed client #3 to ambulate through the group home and to get his wheelchair wheel caught on the edge of the elliptical machine in the hallway of the group home. Further observation revealed client #3 to state "Somebody needs to move this." Subsequent observation revealed staff D had to readjust the client around the exercise machine.	W 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 435	Continued From page 18 Interview with staff D on 6/30/21 revealed the group home received new furniture and the existing furniture had been moved around. Further interview with staff D verified the exercise machine gets in the way of mobility for client's in the home and needed to be moved. Interview with the facility administrator on 6/30/21 verified an exercise machine should not be in the hallway of the group home. Continued interview with the facility administrator revealed the group home should be open in space to allow for free ambulation of all clients. Further interview with the facility administrator revealed the elliptical machine would be moved to support ambulation needs.	W 435		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide teaching relative to adaptive devices for 1 non-sampled client (#4). The finding is: Observation in the group home throughout observations on 6/29/21 and 6/30/21 revealed client #4 to participate in meal preparation, setting the table for meals, meal participation, hygiene	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 436	Continued From page 19 activity and various leisure activities to include shooting basketball outside the group home. Continued observation in the group home on 6/30/21 throughout the morning routine revealed client #4 to have residue on the lens of his eyeglasses. Further observation revealed client #4 to hand his eyeglasses to staff for cleaning upon inquiry from the surveyor regarding the clients ability to clean his glasses. Additional observation revealed staff G to clean client #4's eyeglasses and to then hand the adaptive device back to the client. Review of records for client #4 on 6/30/21 revealed a vision consult dated 5/4/21 that reflected a diagnosis of myopia and early cataract with the need for prescription eyeglasses. Continued review of records for client #4 revealed a person centered plan (PCP) dated 2/19/21. Review of the current PCP for client #4 revealed no training objective relative to care of adaptive equipment. A review of a current skills assessment for client #4 dated 5/17/21 revealed the client keeps up with personal possessions and uses a bedroom key. Interview with the facility qualified intellectual disabilities professional (QIDP) on 6/30/21 verified client #4 is capable of learning to clean his eyeglasses. Continued interview with the QIDP revealed client #4 was in need of new programs and could benefit from a training objective to address proper care and cleaning of his eyeglasses.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least	W 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 440	Continued From page 20 quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to show evidence that quarterly evacuation drills were held for each shift of personnel for Ridgecrest I and Ridgecrest II. The finding is: Review of the facility evacuation drill reports for Ridgecrest I and II on 6/29/21 revealed no evidence of any fire drill conducted for any shift for the review year from 6/2020 through 5/2021. Further review of the facility fire drill reports for both Ridgecrest I and II revealed the last fire drill conducted was on 4/30/2020. Interview with the qualified intellectual disabilities professional (QIDP) on 6/30/21 confirmed there was no evidence the facility had conducted a fire drill since 4/30/20. Continued interview with the QIDP confirmed fire drills should have been conducted quarterly for each shift of personnel.	W 440		