					c	FORM APPROVED MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	34G232	B. WING				09/21/2021		
ROVIDER OR SUPPLIER					<u> </u>			
DGE RESIDENTIAL								
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	(EACH CORRECTIVE ACTION SHO	ULD BE			
INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v)			218					
 CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure physical therapy and occupational therapy services were provided when a need was noted for one of three audit clients (#6). The finding is: Throughout observations on 9/20/21 and 9/21/2021, client #6 remained in his wheelchair. He was assisted with all activities of daily living, including eating. He was fed or fed hand overhand. At dinner in his bedroom on 9/20/2021, two staff balanced a TV tray over his wheelchair and tried to physical manipulate him to feed himself. He was first assisted for approximately one half of the meal with his left hand using a spoon angled for right hand use. The staff switched half way through to use his right and stated he uses both hands. The beverages were placed on the window seal. At breakfast on 9/21/2021, a staff held his plate fed him without his assistance and placed his beverages behind her on the dresser. Both times, a Tablespoon angled for right hand use was used. Review of client #6's individual program plan (IPP) on 9/20/2021 revealed a current plan dated 9/21/2021 which noted he had been in the hospital in June of 2021 in the intensive care unit. 								
hospital in June of 20 The plan also include which were put in plac	21 in the intensive care unit. d new guidelines for eating ce after the hospitalization.							
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DGE RESIDENTIAL SUMMARY STI (EACH DEFICIENC REGULATORY OR I INDIVIDUAL PROGR CFR(s): 483.440(c)(3 The comprehensive fr include sensorimotor This STANDARD is r Based on observatio interviews the facility therapy and occupating provided when a need audit clients (#6). The Throughout observati 9/21/2021, client #6 re He was assisted with including eating. He was overhand. At dinner in two staff balanced a T and tried to physical r himself. He was first a one half of the meal w spoon angled for righ switched half way thrust stated he uses both h placed on the window 9/21/2021, a staff hele his assistance and pla her on the dresser. E angled for right hand Review of client #6's (IPP) on 9/20/2021 re 9/21/2021 which note hospital in June of 20 The plan also include which were put in place	IDENTIFICATION NUMBER: 34G232 ROVIDER OR SUPPLIER DGE RESIDENTIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure physical therapy and occupational therapy services were provided when a need was noted for one of three audit clients (#6). The finding is: Throughout observations on 9/20/21 and 9/21/2021, client #6 remained in his wheelchair. He was assisted with all activities of daily living, including eating. He was fed or fed hand overhand. At dinner in his bedroom on 9/20/2021, two staff balanced a TV tray over his wheelchair and tried to physical manipulate him to feed himself. He was first assisted for approximately one half of the meal with his left hand using a spoon angled for right hand use. The staff switched half way through to use his right and stated he uses both hands. The beverages were placed on the window seal. At breakfast on 9/21/2021, a staff held his plate fed him without his assistance and placed his beverages behind her on the dresser. Both times, a Tablespoon angled for right hand use was used. Review of client #6's individual program plan (IPP) on 9/20/2021 revealed a current plan dated 9/21/2021 which noted he had been in the	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIEN/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI Storm 34G232 B. WING. ROVIDER OR SUPPLIER JAG232 B. WING. DGE RESIDENTIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIT TAG INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) W 3 The comprehensive functional assessment must include sensorimotor development. W 3 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure physical therapy and occupational therapy services were provided when a need was noted for one of three audit clients (#6). The finding is: Throughout observations on 9/20/21 and 9/21/2021, client #6 remained in his wheelchair. He was asisted with all activities of daily living, including eating. He was fed or fed hand overhand. At dinner in his bedroom on 9/20/2021, two staff balanced a TV tray over his wheelchair and tried to physical manipulate him to feed himself. He was first assisted for approximately one half of the meal with his left hand using a spoon angled for right hand use. The staff switched half way through to use his right and stated he uses both hands. The beverages were placed on the window seal. At breakfast on 9/21/2021, a staff held his plate fed him without his assistance and placed his beverages behind her on the dresser. Both times, a Tablespoon angled for right hand use was used. Review of client #6's individual program plan (IPP)	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA ABULDING ABULDING 346232 B. WING CORRECTON STREET ADDRESS, GTY, STATE, ZIP CODE BE WING STREET ADDRESS, GTY, STATE, ZIP CODE IDE RESIDENTIAL DEPROCINCERS PLAN OF CORRECT (EACH CORRECTLE ACTION MADE STATEMENT OF DEPRICIENCES DEPROCINCY INDIVIDUAL PROGRAM PLAN W 218 CFR(s): 483.440(c)(3)(V) W 218 The comprehensive functional assessment must include sensorimotor development. W 218 Throughout observations on 9/20/21 and 9/20/21 and 9/21/20/21, client #6 remained in his wheelchair. W 218 Throughout observations on 9/20/21 and 9/21/20/21, client #6 remained in his wheelchair. Streastate wastest assisted for approximately on half of th	S FOR MEDICARE & MEDICAID SERVICES (x1) PROVIDERSUPPLERCILA (x2) MULTIPLE CONSTRUCTION A BUILDING 34G232 B. WING		

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 09/22/2021

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/22/2021 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G232	B. WING				09/	21/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI	P CODE		
NORTHRI	DGE RESIDENTIAL				88 MITCHELL FORD ROAD CLARKTON, NC 28433			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
W 218 W 249	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Review of the notes by the nurse revealed client #6 was in the hospital from 6/19/2021 until 6/29/2021. He was noted to be taken to the hospital because he did not want to eat or walk or do anything. Interview with the nurse on 9/21/2021 revealed he was discharged on 6/20/2021 as non-ambulatory and they did have physical therapy come three times. The nurse stated she and the PT agreed he needed services but further assessment could not be conducted as Medicaid would not pay. She confirmed that she did not have any documentation from these visitis by PT. She stated client #6 has not been able to transfer to the wheelchair. When the surveyor stated he was in the wheelchair, she revealed that staff must have just begun getting him transferred to the wheelchair then. She stated he really needs further assessment and they are trying to pursue it. She also indicated he needed assessment by occupational theraapy regarding what adaptive equipment he needs now.			218				
	INIS STANDARD IS I	not met as evidenced by:						

If continuation sheet Page 2 of 5

				RIE CONSTRUCTION	A/-> = /		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G232		. ,	PLE CONSTRUCTION G	· · · ·	(X3) DATE SURVEY COMPLETED		
		B. WING		09/21/202			
NAME OF PROVIDER OR SUPPLIER NORTHRIDGE RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE			
				68 MITCHELL FORD ROAD CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
W 249	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 2-	49			

Facility ID: 922313

If continuation sheet Page 3 of 5

	-	D HUMAN SERVICES				FORM	09/22/2021
CENTERS FOR MEDICARE & MI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G232	B. WING		_	09/2	21/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
	DGE RESIDENTIAL		6	8 MITCHELL FORD ROAD			
NORTHRI	DGE RESIDENTIAL		c	CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	it. The banana was b pudding mixture. The Review of client #6's i (IPP) on 9/20/2021 re 9/21/2021 which note hospital in June of 20. The plan also include which were put in plac The guidelines consis instructions dated 6/1 "should be fed by st determine his own bo and assistanceall lic no think liquidsavoid (solids mixed with liqu small bite/sip at a time bites/sipsalternate li solidsencourage {c each bite/sip" Additional review of c aspirating and swallow revealed the following [Client #6] during mea of eating. Prompt [clie perform a dry swallow of liquid or foodpres food or liquid (Alterna liquids) Perform voice throat, make a sound againcheck mouth a make sure clean, wip needed.)" It further no steps should be follow complete.	lended to form a chunky e evening meal was pureed. Individual program plan vealed a current plan dated d he had been in the 21 in the intensive care unit. d new guidelines for eating ce after the hospitalization. Ited of swallowing 8/2021. They noted, aff and not allowed to lus size 100% supervision guids should be nectar thick, d mixed consistencies uids like cereal in milkone eclear mouth between iquids with lient #6] to swallow x 2 for lient #6] to swallow x 2 for staff will monitor and feed altimes to ensure a safe rate ent #6] to clear his throat and v in between each spoonful eent teaspoon amount of te bites of puree food and o check, promptto clear or clear throat and swallow after each swallow and es mouth with napkin (as oted that all of the above	W 249				

Facility ID: 922313

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/22/2021 RM APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G232	B. WING			09	9/21/2021	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHRI	DGE RESIDENTIAL				68 MITCHELL FORD ROAD CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
W 249	Continued From page			249	DEFICIENCY)			

Event ID: 17V911

Facility ID: 922313

If continuation sheet Page 5 of 5