STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G232	A. BUILDING _____ B. WING _____	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 218	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 hospital in June of 2021 in the intensive care unit. The plan also included new guidelines for eating which were put in place after the hospitalization. The plan noted he was ambulatory.	W 218		

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

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W 218	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.	W 218		
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:	W 249		

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W 249	Continued From page 2	W 249		

Based on observations, record reviews and interviews, the facility failed to assure all plans for rate of eating and swallowing were consistently implemented as written This affected 1 of 3 audit clients (#6). The finding is:

Throughout observations on 9/20 and 9/21/2021, client #6 remained in his wheelchair. He was assisted with all activities of daily living, including eating. He was fed by staff 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 ate heaping tablespoons of food at a time. He was first assisted for approximately one half of the meal with his left hand using a tablespoon 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. When he was given a beverage near the end of the meal they mixed thickener in water and immediately physically assisted him to drink it all before it became thick. When questioned the staff were both unsure what the consistency should look like but mixed the milk to nectar consistency and fed it to him with physical manipulation. 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, the tablespoon angled for right hand use was used. He was assisted and fed without pauses or encouragement to swallow. At breakfast, the staff fed two bites to several swallows of beverage at a time. His breakfast consistency was barely moist finely chopped. The toast could described as appearing like dampened granola. The cereal was finely chopped in a blender and the staff took it into him dry but then poured thickened milk over

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W 249	Continued From page 3	W 249		

it. The banana was blended to form a chunky pudding mixture. The evening meal was pureed.

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. The plan also included new guidelines for eating which were put in place after the hospitalization. The guidelines consisted of swallowing instructions dated 6/18/2021. They noted, "...should be fed by staff and not allowed to determine his own bolus size... 100% supervision and assistance...all liquids should be nectar thick, no think liquids...avoid mixed consistencies (solids mixed with liquids like cereal in milk...one small bite/sip at a time...clear mouth between bites/sips...alternate liquids with solids...encourage {client #6] to swallow x 2 for each bite/sip...."

Additional review of client #6's guidelines for aspirating and swallowing dated 7/8/2021 revealed the following: "Staff will monitor and feed [Client #6] during mealtimes to ensure a safe rate of eating. Prompt [client #6] to clear his throat and perform a dry swallow in between each spoonful of liquid or food...present teaspoon amount of food or liquid (Alternate bites of puree food and liquids) Perform voice check, prompt..to clear throat, make a sound or clear throat and swallow again...check mouth after each swallow and make sure clean, wipes mouth with napkin (as needed.)" It further noted that all of the above steps should be followed until the meal is complete.

Interview with the acting qualified professional (QP) on 9/21/2021 confirmed the guidelines are

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W 249	Continued From page 4 current and should have been followed as written.	W 249		