STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		

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

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E 006	Continued From page 1 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to perform a risk hazard assessment for the group home. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Review on 11/29/21 of the Emergency Plan (EP) dated 2/7/20, revealed the plan did not provide specific information regarding a facility based and community-based risk assessment using an all hazard approach including the event of a natural disaster and other potential hazards. Interview on 11/30/21 with the Consultant revealed that the EP did not contain as risk	E 006		

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E 006	Continued From page 2 hazard assessment.	E 006		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s).	E 020		

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E 020	Continued From page 3 (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuating locations based on a community and facility risk assessments. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Review on 11/30/21 of the facility's EP plan dated 2/7/20 revealed the plan did not include any information in regards to the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio-terrorism and other emergencies. Interview on 11/30/21 with the Consultant, revealed after review of the EP he could not locate an evacuation policy that pertained to this facility.	E 020		

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E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to develop policy and procedures in their emergency preparedness (EP) plan for sheltering in place. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is:	E 022		

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E 022	Continued From page 5 Review on 11/30/21 of the facility's EP dated 2/7/21 did not include situations that would call for the clients and staff to shelter in place. Interview on 11/30/21 with the Consultant revealed the EP did not include any information on shelter in place.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at	E 025		

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E 025	Continued From page 6 §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility's emergency preparedness (EP) plan failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The findings is: Review on 11/30/21 of the facility's 2020 EP revealed there was no list of accommodations or agreements for housing for emergency purposes. Interview on 11/30/21 with the Consultant revealed after reviewing the facility's EP it listed accommodations for another group home in another county. The Consultant could not find any accommodations for this particular facility.	E 025		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1),	E 030		

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E 030	Continued From page 7 §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030		

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E 030	Continued From page 8 (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following:	E 030		

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E 030	Continued From page 9 (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Review on 11/30/21 of the facility's EP plan did not include any information on the clients who reside in the home. Further review revealed the EP plan did not include any information on the guardians, direct care staff or the current list of management. Interview on 11/30/21 with the Consultant revealed that after review of the EP, he noticed former staff were still listed in the EP and that there was no information on clients, guardians or direct care staff for this particular home.	E 030		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility furniture was in good repair. The finding is:	W 104		

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W 104	Continued From page 10 Observations conducted in the home on 11/29/21 at 7:00 PM revealed that the right rear leg on the three cushion leather sofa was missing and the sofa rested on blocks. The sofa was leaned against the wall. Client #6 was sitting on the sofa watching television. Interview with the Consultant on 11/30/21 revealed after speaking to the facilty's home inspector he learned that a work order was issued last month, on unknown date, to replace the sofa. He did not know the status of the purchase. Interview on 11/30/21 with the Regional Director (RD) revealed that the work order was received early in October 2021 and had been approved by management for purchase. The RD discovered that the purchase agent with the facility resigned mid October and no one followed up on the purchase.	W 104		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure assessments were conducted within 30 days for 1 of 1 newly admitted clients (#4). The finding is: Review on 11/29/21 of newly admitted client #4's record revealed he was admitted on 10/25/21 and his individual program plan (IPP), nursing,	W 210		

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W 210	Continued From page 11 therapy, vision and dental evaluations were not completed. Interview on 11/30/21 with the Consultant, revealed that after conversing with the QIDP he learned that the IPP had not been scheduled this month and there was no record of the other evaluations.	W 210		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure current individual program plans (IPP) were available all relevant staff. This affected 5 of 6 audit clients (#1, #2, #3, #5 and #6). The finding is: Interviews with Staff D and the center manager (CM) on 11/29/21 revealed when the clients resumed vocational services this year, the updated IPP did not accompany them. The CM revealed she returned to her office to look for copies of the IPP's but only had the 2020 IPP's on hand. Interview on 11/29/21 with the Consultant revealed that he recalled the qualified intellectual disabilities professional (QIDP) place the 2021 in a binder for the vocational center but did not know when the material was left with the center manager.	W 248		
W 249	PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 12 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 each client received a continuous active treatment program consisting of needed interventions and services as identified in the individual program plan (IPP) for 1 of 5 audit clients (#3) in the areas of adaptive equipment and meal preparation. The findings are: A. During observations at the day program on 11/29/21 at 11:30 AM, client #3 was fed with a built up spoon by Staff E. Further observations in the home, during dinner on 11/29/21 at 6:00 PM, Staff B used a built up spoon to feed client #3. Review on 11/29/21 of client #3's annual nursing evaluation dated 2/11/21 revealed that he was on pureed diet and used a maroon spoon. Interview on 11/30/21 with the Consultant revealed that Qualified Intellectual Disabilities Professional (QIDP) conveyed to him today that the maroon spoon was supposed to be discontinued. The Consultant could not find any assessment in the IPP stating the maroon spoon	W 249		

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	34G302	A. BUILDING _____ B. WING _____	11/30/2021

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PINE RIDGE GROUP HOME	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 249	Continued From page 13 was discontinued. B. During observations in the home on 11/29/21 at 6:15 PM, Staff A was observed in the kitchen, stirring thick-it powder in a cup for client #3. She allowed the the beverage to sit for several minutes before offering to client #3 to drink. Review on 11/29/21 of client #3's IPP dated 1/23/21 revealed he had a goal to participate in stirring his thickened liquid. Interview on 11/30/21 with the Consultant revealed that staff should allow clients to participate in meal preparation tasks if they have a goal to enhance their skills.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, nursing services failed to ensure that staff were sufficiently trained in medication administration for 2 of 5 audit clients (#5 and #6). The finding is: During evening observation in the home on 11/29/21 at 7:25 PM, Staff B had already taken pills out of their containers, placed in a medicine cup before she called client #6 to the medication room to ingest her medication. Client #6 walked into the room, took the cup and swallowed the	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G302	A. BUILDING _____ B. WING _____	11/30/2021

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W 340	Continued From page 14 pills, then drunk the poured water in a cup. During evening observations in the home on 11/29/21 at 7:26 PM, Staff B removed three liquid medications from the cabinets and poured two of the medications into medicine cups and the other liquid into an oral syringe, without client #5 being present. Next, Staff B signed off on the bubble packs, then pushed the pills through the foil and placed in another medicine cup for client #5. Staff B stuck her head out of the medication room door to call client #5 to come take his medication. Staff A informed Staff B that he was getting dressed from taking a shower. Staff B waited for client #5 to be wheeled into the medication room, then proceeded to give him all of this medications. Review on 11/30/21 of the facility's undated Medication Administration inservice did not include any language on preparing the medication in the presence of clients who could receive it in the medication room. Interview on 11/30/21 with client #6 revealed that Staff B was the only employee who had her pills ready for her when she took them. Interview on 11/30/21 with Staff C revealed that the nurse had recently visited the home to watch staff pass medications and it had never been his practice to place any medications in medicine cups before the clients arrived to the medication room. Interview on 11/30/21 with the nurse revealed that she has witnessed medications being prepared outside the presence of clients in the home and did not correct staff. The nurse explained that client #6 was on some controlled medications and	W 340		

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	34G302	A. BUILDING _____ B. WING _____	11/30/2021

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W 340	Continued From page 15 she would not recommend that she dispense her medications in front of staff in case she wasted a pill.	W 340		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that only authorized persons had access to the key to the drug storage area. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: During evening observations of the medication administration on 11/29/21 at 7:30 PM, Staff B was unable to retrieve medications from the locked utility container inside of the medication room. The key that Staff B tried to use did not work. Staff B called the Home Manager (HM) for assistance. The HM grabbed a key from her opened office and gave the key to Staff B to open the container full of medications. Review on 11/30/21 of an undated Medication Administration inservice read: "Keep all medication keys issues/assigned to you on your person at all times." Interview with the Consultant on 11/30/21 revealed that on 11/29/21 he observed the HM in the medication room and speculated that she might have forgotten to put the key back in the lock box. Interview with the nurse on 11/30/21 revealed that	W 383		

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W 383	Continued From page 16 the key to the medication room should be kept on the person passing medications.	W 383		