	MENT OF HEALTH		FORM APPROVED				
	RS FOR MEDICARE	& MEDICAID SERVICES	r		0	<u>MB NO.</u>	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G296	B. WING _			02/08/2022	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				2 UNION HEIGHTS BOULEVARD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 242	CFR(s): 483.440(c) The individual program those clients who lask ills essential for proprint of the personal hygiene, or bathing, dressing, gram of basic needs), untat the client is deviacquiring them. This STANDARD is Based on observation interview, the facility person-centered plactients (#4) included address observed refinding is: Morning observation 2/8/22 at 7:55 AM reformed staff C of as pointing out the client show Observation of clier bottoms to be black with dry skin. It show informed staff C of as pointing out the continued observation of client feet. Further or to enter the bathroom independently with dry skin. It shows the survey of records fa person-centered place in the survey of records fa person-centered for the survey of client #4	(6)(iii) ram plan must include, for ack them, training in personal privacy and independence imited to, toilet training, dental hygiene, self-feeding, grooming, and communication til it has been demonstrated velopmentally incapable of s not met as evidenced by: tion, record review and y failed to ensure the an (PCP) for 1 of 3 sampled d training in personal skills to needs relative to bathing. The ns in the group home on evealed client #4 to complain ut pain in their left foot, and their feet to the surveyor. In #4's feet revealed the c in color as well as cracked uld be noted the surveyor then client #4's complaint as well condition of client's feet. tion at 8:05 AM revealed staff f4 to take a shower and wash bservation revealed client #4 om and proceed to shower out any monitoring or	W 24	42			
	with dry skin. It sho informed staff C of as pointing out the Continued observat C to prompt client # their feet. Further o to enter the bathroo independently with assistance. Review of records f a person-centered Review of client #4	uld be noted the surveyor then client #4's complaint as well condition of client's feet. tion at 8:05 AM revealed staff #4 to take a shower and wash bservation revealed client #4 om and proceed to shower out any monitoring or for client #4 on 2/8/22 revealed plan (PCP) dated 4/4/21.					

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

TITLE

(X6) DATE

PRINTED: 02/18/2022

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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G296 B. WING 02/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 UNION HEIGHTS BOULEVARD STONERIDGE SALISBURY, NC 28144 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 242 Continued From page 1 W 242 eyeglass maintenance, and activity schedule. Further review of client #4's record revealed a behavior support plan (BSP) dated 4/28/21. Review of the BSP indicated target behaviors of making false accusations, invading privacy, and inappropriate touching. Further review of the BSP did not reveal any behaviors relative to bathing concerns. Interview with staff C on 2/8/22 revealed client #4 often refuses to bathe and will frequently only stand under the shower water without scrubbing. Further interview with staff C also revealed that at times client #4 will make false accusations and staff will ignore the client. Interview with the facility nurse and qualified intellectual disabilities professional (QIDP) on 2/8/22 confirmed client #4's PCP and BSP are current. Further interview with the nurse confirmed she has been in contact with staff and plans to assess the condition of client's feet later today. Continued interview with the nurse and QIDP confirmed client #4 would benefit from a showering program. W 368 DRUG ADMINISTRATION W 368 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 3 sampled clients (#4). The finding is: Observations in the group home on 2/8/22 at 7:50 AM revealed client #4 to enter the medication room to prepare for medication administration.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	02/18/2022 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT A. BUILDING				E SURVEY IPLETED
		34G296	B. WING	÷		02/	08/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	RIDGE				222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
W 368	Continued observat administer the folloo Levothyroxine 100 f Clobazam 10 mg at observations revea #4 Levothyroxine 11 participated in the b Continued observat the medication pact basket and check of dispensed. Review of the recor person-centered pla medication adminis 2/3/22 for client #4 Levothyroxine, 100 client #4 for thyroid Further review of th #4 revealed that Le administered every Interview with the fa client #4 should hav Levothyroxine 100 an empty stomach Continued interview that staff should hav medications as pre- also confirmed that performing medicat in-service training of FOOD AND NUTRI CFR(s): 483.480(a)	tions revealed staff to wing medications to client #4: mcg, Vimpat 200mg, nd Hydrocort 10 mg. Further led staff to administer to client 00 mcg after the client oreakfast meal at 7:30 AM. tions revealed staff to return ket to client #4's medication off the medication as rd for client #4 revealed a an dated 4/4/21. Review of the tration record (MAR) dated revealed the medication mcg to be administered to hormone replacement. the 2/3/22 MAR form for client vothyroxine should be morning before breakfast. acility nurse on 2/8/22 revealed we been given the mcg prior to breakfast and on to aid in absorption. with the facility nurse verified ve dispensed client #4's scribed. The facility nurse she will ensure that all staff tion administration will receive on medication instructions. TION SERVICES o(1) ceive a nourishing, ncluding modified and	W 3				

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		AND HUMAN SERVICES				FORM	02/18/2022 APPROVED 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ì í		E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G296	B. WING			02/(08/2022
NAME OF F	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	:	
STONER	IDGE				22 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	Continued From pa	ge 3	W 4	160			
	Based on observat review, the facility fa specially prescribed	s not met as evidenced by: tions, interviews and record ailed to assure clients received d diet as required for 2 of 3 and #5) relative to diet indings are:					
	A. The facility failed prescribed for clien consistency. For ex						
	PM revealed staff to the dinner meal. Th the following menu gravy, mashed pota and sugar free beve observations reveal salisbury steak in th observations reveal pieces of the salisb hands. Observation	led staff to cut client #5's nree large pieces. Further led client #5 to eat large oury steak with a spoon and his ns did not reveal staff to salisbury steak to a ground					
	revealed a person of 4/21/21. Continued the following diagno congestive heart fa disorder (OCD), sp hypertension, hyper repair, sleep disord Continued review o revealed an occupa assessment dated	rd for client #5 on 2/8/22 centered plan (PCP) dated review of the PCP revealed osis for client #5: I/DD severe, ilure, obsessive compulsive eech impairment, rthyroidism, inguinal hernia er and cerebral palsy. of the record for client #5 ational therapy (OT) 2/25/20 which states that client round consistency diet with					

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		AND HUMAN SERVICES			FOR	D: 02/18/2022 M APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) D.	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G296	B. WING		0	2/08/2022	
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP C			
STONER	IDGE			222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
W 460	 thin liquids due to h Further review of th evaluation dated 5// #5 is at a high risk f consistency is need. Interview with the fa that staff should ha salisbury steak to a the client's high risk the qualified intelled (QIDP) on 2/8/22 re prepared client #5's as prescribed. Furt verified that client # Interview with the G be in-serviced on fo as prescribed. B. The facility fails prescribed for clien consistency. For et Afternoon observat 2/7/22 at 5:35 PM r #4's plate for the dii consisted of the foll of salisbury steak w green beans, fruit of Continued observat a whole piece of sa At no point during th salisbury steak for as prescribed. Morning observatio 2/8/22 at 7:20 AM r dining table to prep 	is congestive heart failure. he record revealed a nursing 24/21 which states that client for choking and ground ded during mealtimes. acility nurse on 2/8/22 revealed ve prepared client #5's ground consistency due to a for choking. Interview with ctual disabilities professional evealed that staff should have s meat to a ground consistency ther interview with the QIDP 5's prescribed diet is current. QIDP confirmed that staff will bollowing client specified diets ed to follow specified diets as t #4 relative to diet	W 46	50			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/18/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G296	B. WING	i		02/08/2022	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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W 460	Continued From par menu items: Oatm almond milk and wa revealed client #4 to toast with both hand observation did stat client #4 into ½" col Review of the recor revealed a person of 4/4/21. Continued r following diagnosis ADHD, Epilepsy, Do Hypthyroidism, Gra surgery and Asthma record for client #4 therapy (OT) asses states that client #4 consistency due to mal seizures. Interview with the fat that staff should ha salisbury steak to a client's high risk for qualified intellectua (QIDP) on 2/8/22 re prepared client #4's prescribed. Further verified that client #	age 5 heal, cheese toast, yogurt, ater. Continued observations o eat a whole piece of cheese ds. At no point during the ff cut the cheese toast for nsistency as prescribed. rd for client #4 on 2/8/22 centered plan (PCP) dated review of the PCP revealed the for client #4: I/DD, moderate,	W 2		DEFICIENCY)		

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