STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G296	A. BUILDING _____ B. WING _____	02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONERIDGE	222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144

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W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the person-centered plan (PCP) for 1 of 3 sampled clients (#4) included training in personal skills to address observed needs relative to bathing. The finding is: Morning observations in the group home on 2/8/22 at 7:55 AM revealed client #4 to complain to the surveyor about pain in their left foot, and subsequently show their feet to the surveyor. Observation of client #4's feet revealed the bottoms to be black in color as well as cracked with dry skin. It should be noted the surveyor then informed staff C of client #4's complaint as well as pointing out the condition of client's feet. Continued observation at 8:05 AM revealed staff C to prompt client #4 to take a shower and wash their feet. Further observation revealed client #4 to enter the bathroom and proceed to shower independently without any monitoring or assistance. Review of records for client #4 on 2/8/22 revealed a person-centered plan (PCP) dated 4/4/21. Review of client #4's PCP indicated training objectives for brushing teeth, fire safety, sharing,	W 242		

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

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W 242	Continued From page 1 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 242		
W 368	DRUG ADMINISTRATION 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.	W 368		

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W 368	Continued From page 2 Continued observations revealed staff to administer the following medications to client #4: Levothyroxine 100 mcg, Vimpat 200mg, Clobazam 10 mg and Hydrocort 10 mg. Further observations revealed staff to administer to client #4 Levothyroxine 100 mcg after the client participated in the breakfast meal at 7:30 AM. Continued observations revealed staff to return the medication packet to client #4's medication basket and check off the medication as dispensed. Review of the record for client #4 revealed a person-centered plan dated 4/4/21. Review of the medication administration record (MAR) dated 2/3/22 for client #4 revealed the medication Levothyroxine, 100 mcg to be administered to client #4 for thyroid hormone replacement. Further review of the 2/3/22 MAR form for client #4 revealed that Levothyroxine should be administered every morning before breakfast. Interview with the facility nurse on 2/8/22 revealed client #4 should have been given the Levothyroxine 100 mcg prior to breakfast and on an empty stomach to aid in absorption. Continued interview with the facility nurse verified that staff should have dispensed client #4's medications as prescribed. The facility nurse also confirmed that she will ensure that all staff performing medication administration will receive in-service training on medication instructions.	W 368		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460		

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This STANDARD is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to assure clients received specially prescribed diet as required for 2 of 3 sampled clients (#4 and #5) relative to diet consistency. The findings are:

A. The facility failed to follow specified diets as prescribed for client #5 relative to diet consistency. For example:

Observations in the group home on 2/7/22 at 5:35 PM revealed staff to prepare client #5's plate for the dinner meal. The dinner meal consisted of the following menu items: salisbury steak with gravy, mashed potatoes, green beans, fruit cup and sugar free beverage. Continued observations revealed staff to cut client #5's salisbury steak in three large pieces. Further observations revealed client #5 to eat large pieces of the salisbury steak with a spoon and his hands. Observations did not reveal staff to prepare client #5's salisbury steak to a ground consistency as prescribed.

Review of the record for client #5 on 2/8/22 revealed a person centered plan (PCP) dated 4/21/21. Continued review of the PCP revealed the following diagnosis for client #5: I/DD severe, congestive heart failure, obsessive compulsive disorder (OCD), speech impairment, hypertension, hyperthyroidism, inguinal hernia repair, sleep disorder and cerebral palsy. Continued review of the record for client #5 revealed an occupational therapy (OT) assessment dated 2/25/20 which states that client #5 should have a ground consistency diet with

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thin liquids due to his congestive heart failure. Further review of the record revealed a nursing evaluation dated 5/24/21which states that client #5 is at a high risk for choking and ground consistency is needed during mealtimes.

Interview with the facility nurse on 2/8/22 revealed that staff should have prepared client #5's salisbury steak to a ground consistency due to the client's high risk for choking. Interview with the qualified intellectual disabilities professional (QIDP) on 2/8/22 revealed that staff should have prepared client #5's meat to a ground consistency as prescribed. Further interview with the QIDP verified that client #5's prescribed diet is current. Interview with the QIDP confirmed that staff will be in-serviced on following client specified diets as prescribed.

B. The facility failed to follow specified diets as prescribed for client #4 relative to diet consistency. For example:

Afternoon observations in the group home on 2/7/22 at 5:35 PM revealed staff to prepare client #4's plate for the dinner meal. The dinner meal consisted of the following menu items: 2 pieces of salisbury steak with gravy, mashed potatoes, green beans, fruit cup and sugar free beverage. Continued observations revealed client #4 to eat a whole piece of salisbury steak with both hands. At no point during the observation did staff cut the salisbury steak for client #4 into ½" consistency as prescribed.

Morning observations in the group home on 2/8/22 at 7:20 AM revealed client #4 to sit at the dining table to prepare for the breakfast meal. The breakfast meal consisted of the following

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menu items: Oatmeal, cheese toast, yogurt, almond milk and water. Continued observations revealed client #4 to eat a whole piece of cheese toast with both hands. At no point during the observation did staff cut the cheese toast for client #4 into ½" consistency as prescribed.

Review of the record for client #4 on 2/8/22 revealed a person centered plan (PCP) dated 4/4/21. Continued review of the PCP revealed the following diagnosis for client #4: I/DD, moderate, ADHD, Epilepsy, Down Syndrome, Hypthyroidism, Grand Mal seizures, tongue surgery and Asthma. Continued review of the record for client #4 revealed an occupational therapy (OT) assessment dated 3/2/21 which states that client #4 should have a ½ inch consistency due to a history of choking and grand mal seizures.

Interview with the facility nurse on 2/8/22 revealed that staff should have prepared client #4's salisbury steak to a ½" consistency due to the client's high risk for choking. Interview with the qualified intellectual disabilities professional (QIDP) on 2/8/22 revealed that staff should have prepared client #4's meat to a 1/2" consistency as prescribed. Further interview with the QIDP verified that client #4's prescribed diet is current. Interview with the QIDP confirmed that staff will be in-serviced on following client specified diets as prescribed.