	-	ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DAT	E SURVEY PLETED
		34G250	B. WING		09	/13/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RIDGEFIE	LD HOME			730 FISHER RIDGE DRIVE MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	RECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
W 382	CFR(s): 483.460(l)(2) The facility must keep locked except when b administration. This STANDARD is a Based on observation failed to ensure all mo The finding is: Observations during for revealed a cardboard in bubble packs as we clients names who re sitting on the floor in for medication closet. Co revealed all clients to medication room to re Further observation re outside contractor an sit within close proxim containing multiple m During an immediate staff F revealed the m in the box in preparat pharmacy for disposit with staff F revealed I the box had been sitti Further interview with revealed the medication the pharmacy to be p interview with the faci medications should b closet and controlled	all drugs and biologicals being prepared for not met as evidenced by: ns and interviews, the facility edications remained locked. The 9/12/22 - 9/13/22 survey box filled with medications ell as topicals labeled with side in the group home the office adjacent to the portinued observations enter and exit the exceive their medication. evealed staff, clients an d surveyors to walk, stand or nity of the cardboard box edications in bubble packs. interview on 9/13/22 with medications had been sitting	W 38	2		
W 508	locked. COVID-19 Vaccinatio CFR(s): 483.430(f)(1)	-	W 50	8		
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/2022

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/16/2022 APPROVED 0. 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED				
34		34G250	B. WING			09/13/2022				
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE					
			730 FISHER RIDGE DRIVE							
RIDGEFIELD HOME				MONROE, NC 28110						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
W 508	<ul> <li>§ 483.430 Condition of staffing.</li> <li>(f) Standard: COVID-1 staff. The facility must policies and procedure fully vaccinated for CO this section, staff are of if it has been 2 weeks completed a primary of COVID-19. The completed a primary of the administration of a multi-dose vaccine.</li> <li>(1) Regardless of clin contact, the policies at to the following facility care, treatment, or oth and/or its clients:</li> <li>(i) Facility employees;</li> <li>(ii) Licensed practition (iii) Students, trainees (iv) Individuals who prother services for the under contract or by contact or by contact and other staff of this section; and (ii) Staff who exclusive telemedicine services and who do not have clients and other staff of this section; and (ii) Staff who provide facility that are perform the facility setting and contact with clients are paragraph (f)(1) of this section; and</li> </ul>	of Participation: Facility 19 Vaccination of facility at develop and implement es to ensure that all staff are DVID-19. For purposes of considered fully vaccinated a or more since they vaccination series for oletion of a primary COVID-19 is defined here of a single-dose vaccine, or all required doses of a nical responsibility or client and procedures must apply v staff, who provide any her services for the facility s, and volunteers; and rovide care, treatment, or facility and/or its clients, other arrangement. procedures of this section lowing facility staff: ely provide telehealth or a outside of the facility setting any direct contact with specified in paragraph (f)(1) support services for the med exclusively outside of who do not have any direct and other staff specified in	W 50	08						

Facility ID: 922471

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	S FOR MEDICARE &					O. 0938-039	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		34G250	B. WING		09	9/13/2022	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGEFIE	LD HOME			30 FISHER RIDGE DRIVE MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
W 508	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines		W 508				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/16/2022 APPROVED 0: 0938-0391			
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED				
		34G250	B. WING		_	09/ <sup>,</sup>	13/2022			
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	_				
	D LIONE			730 FISHER RIDGE DRIVE						
RIDGEFIEI				MONROE, NC 28110						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
W 508	exemptions from vacc and dated by a license the individual requesti is acting within their re as defined by, and in applicable State and I ensuring that such do (A) All information spe authorized COVID-19 contraindicated for the and the recognized cli contraindications; and (B) A statement by the recommending that th exempted from the fac vaccination requireme recognized clinical cor (ix) A process for ensu- secure documentation staff for whom COVID temporarily delayed, a CDC, due to clinical p considerations, includ individuals with acute COVID-19, and individ monoclonal antibodies for COVID-19 treatme (x) Contingency plans vaccinated for COVID Effective 60 Days After (ii) A process for ensu- paragraph (f)(1) of this vaccinated for COVID who have been granter	taff requests for medical cination, has been signed ed practitioner, who is not ing the exemption, and who espective scope of practice accordance with, all ocal laws, and for further cumentation contains: ecifying which of the vaccines are clinically e staff member to receive inical reasons for the l e authenticating practitioner re staff member be cility's COVID-19 ents for staff based on the ntraindications; uring the tracking and n of the vaccination status of 0-19 vaccination must be as recommended by the recautions and ing, but not limited to, illness secondary to duals who received s or convalescent plasma ent; and a for staff who are not fully 1-19. er Publication: rring that all staff specified in as section are fully 1-19, except for those staff	W 50		DEFICIENCY)					
	Stall for WHORT COVID	- 19 Vaccination must be								

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/16/2022 // APPROVED ). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
34G250		34G250	B. WING			_	09/13/2022		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
RIDGEFIE	LD HOME		730 FISHER RIDGE DRIVE MONROE, NC 28110						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 508	temporarily delayed, a CDC, due to clinical p considerations; This STANDARD is r Based on observation interview, the facility f procedures for COVIE mask. The finding is: Upon arrival and durin home on 9/12/22 reve group home to not we observation at 12:42 f contractor to enter the room area not wearin was performed. At no observations did staff wear a mask. Morning observations 9/13/22 revealed staff wear a mask during th of 1 staff. Continued to wear a cloth mask home and during mee no point during survey wearing a mask put a the group home. Interview with staff F of staff F was made awa procedure requiring m working in the group f with staff F revealed t via email regarding an	as recommended by the precautions and all of the policies and all of follow policies and 0-19 relative to staff wearing ang observations in the group ealed all staff working in the ear a mask. Continued PM revealed an outside a home and medication g a mask and no screening o point during survey working in the group home on f working in the group home on f working in the home to not be survey with the exception observations did staff not mask on while working in the group dication administration. At y observations did staff not mask on while working in the group home on 9/13/22 revealed that are of the policy and hask to be worn while home. Continued interview hat the facility notified staff hy changes to the policy and hication stating mask are no	W	508					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/16/2022 MAPPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
34G250			B. WING			09/13/2022		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGEFIELD HOME			730 FISHER RIDGE DRIVE MONROE, NC 28110					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR( DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
W 508	to wear mask while w Continued interview v	lity's policy requires all staff rorking in the group home. vith the facility nurse verified n the group home should be	W	508				

Facility ID: 922471

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