DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	01/24/2023

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
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure outside services met the needs of 1 of 3 audit clients (#5). The finding is: During lunch observations at the day program on 1/23/23 at 11:28am, Staff G fed client #5 his entire meal without his assistance. Additional observations indicated no adaptive dining equipment was utilized at the meal. Further observations revealed the client consumed three food items including one cup of pudding, one side dish and one meat dish. The side item was pureed smooth while the meat dish was minced and moist. The client consumed his food without difficulty. Interview on 1/23/23 with Staff G revealed client #5 does not utilize any adaptive dining equipment at the day program. Additional interview revealed the client consumes a pureed diet and is normally fed by staff. Interview on 1/23/23 with the Day Program Director also indicated client #5 does not utilize any adaptive dining equipment and his food is a pureed consistency. Additional interview revealed if the client's food is not properly pureed, the home should be notified. Review on 1/24/23 of client #5's Individual Program Plan (IPP) dated 3/31/22 revealed, "Occupational Therapist has recommended	W 120		

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

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W 120	Continued From page 1 adaptive eating equipment (enlarged handle eating utensil, sectional plate with high sides, weighted cups and dycem mat) and a clothing protector due to food spillage and self supporting feeding." Additional review of the plan noted the client "eats with minimal physical assistance...drinks from cup with assistance." Further review of client #5's nutritional evaluation 11/18/22 revealed he receives a regular pureed consistency diet. Interview on 1/24/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 should consume a pureed diet at the day program and his identified adaptive dining equipment should also be available at the day program for use at lunch. The QIDP also indicated the client can feed himself given assistance. The QIDP acknowledged the day program should be consistently meeting client #5's needs as indicated.	W 120		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to assist client #2 to use her walker as needed. This affected 1 of 3 audit clients. The finding is: During observations at the day program on 1/23/23 from 11:00am - 11:43am, client frequently walked around classroom without a walker.	W 189		

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W 189	Continued From page 2 Although the client's walker was positioned against a wall in the classroom, staff in the room did not prompt or assist the client to use the walker. During evening observations in the home on 1/23/23 from 3:26pm - 6:45pm, client #2 consistently walked to various areas of the home without using her walker. The client frequently walked short distances using the walker, then left the walker and continued walking without the device. Although several staff were in the area, client #2 was not prompted or assisted to use the walker. Interview on 1/23/23 with Staff G revealed client #2 is "very unstable" and should be using her walker. The staff noted, "We have to remind her." Review on 1/23/23 of client #2's Physical Therapy evaluation dated 12/31/22 revealed, "[Client #2] is high risk for falls...Once the walker arrives, I suspect [Client #2] will not consistently use the walker secondary to impulsivity and appearance...PT will guide Nursing/staff on walker adjustment and use upon arrival." Interview on 1/24/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 uses a walker due to recent falls. Additional interview indicated the client does not like to use her walker and staff should "encourage" the client use the walker.	W 189		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the	W 210		

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W 210	Continued From page 3 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 ensure client #2 received all assessments within 30 days after adminission. This affected 1 of 3 audit clients. The finding is: Review on 1/24/23 of client #2's record revealed she was admitted to the facility on 11/8/22. Additional review of the client's record did not include an assessment of her vision or an Occupational Therapy assessment. Interview on 1/24/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 has not had an assessment of her vision and no Occupational Therapy evaluation has been completed since her admission.	W 210		
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, the facility failed to ensure all staff were sufficiently trained to wear masks appropriately to prevent the potential spread of COVID-19. The finding is: A. Upon arrival to the day program on 1/23/23 at	W 340		

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W 340	Continued From page 4 11:00am, a sign posted on an interior door at the facility noted, "Notice: Face masks required." During observations in a classroom at the day program on 1/23/23, two of four staff were not wearing a face mask while interacting with clients. Interview on 1/23/23 with one of the two staff (Staff H) revealed she had not been told face masks are mandatory and she thought they were optional. Interview on 1/23/23 with the Day Program Director revealed they have been encouraging staff to were face masks and face masks are available upon request. Additional interview indicated face masks may have "optional" at the day program now since COVID cases have gone down. Interview on 1/24/23 with the Qualified Intellectual Disabilites Professional (QIDP) revealed she was not sure what the face mask policy was at the day program; however, she thought they were required to wear them. B. During evening observations in the home on 1/23/23, Staff D and Staff F wore a single surgical face mask covering their nose and mouth during interactions with clients. Review on 1/23/23 of the facility's employee COVID-19 vaccination records revealed Staff D and Staff F had received approvals for religious exemptions and were not vaccinated against COVID-19. Additional review of staff training documentation dated 6/9/22 noted, "Any staff not vaccinated must wear additional PPE such as N95 mask supplied by the company."	W 340		

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W 340	Continued From page 5 Interview on 1/23/23 with the QIDP confirmed Staff D and Staff F were not vaccinated due to a religious exemption. Additonal interview indicated unvaccinated staff also have the option of wearing a face shield while on duty.	W 340		