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 _____	02/14/2023

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

(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 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 the exterior and interior of the facility was sanitary and orderly. The findings are: Observations during the 2/13/23-2/14/23 survey revealed a brown substance covering a large area behind client #2's room. Continued observations revealed the brown substance to be splattered and dry behind the door. Observations on 2/14/23 at 7:10 AM revealed the paneling on the wall by the bathroom to be loose and hanging. Continued observations at 7:15 AM revealed this surveyor to push the paneling close to the wall as client #4 was observed to pace and punch the wall area while having a tantrum in the hallway. Subsequent observations throughout the 2/13/23-2/14/23 survey revealed a transfer chair to sit outside close to the side door. Observations also revealed the transfer chair to be wet to the touch. Additional observations revealed a pair of shoes to be outside of the back door area. Observations also revealed the shoes to be wet to the touch. Interview with staff on 2/14/23 revealed they were not aware of the brown substance splattered behind client #2's door. Continued interview with staff revealed the splatter came from client #2	W 104		

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

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	34G296	A. BUILDING _____ B. WING _____	02/14/2023

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STONERIDGE	222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144

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W 104	Continued From page 1	W 104		

having a behavior one day last week and they didn't completely clean the area. Interview with staff also revealed they were aware of the paneling being loose in the hallway close to the bathroom. Further interview with staff revealed they submitted a work order for the paneling being loose on the wall.

Subsequent interview with staff on 2/14/23 revealed the transfer chair belonged to client #6 and it is too small for the client. Continued interview with staff revealed a new transfer chair has been purchased and the older chair was placed outside to be discarded.

Additional interview with staff revealed the shoes belong to client #4. Staff also revealed during the interview client #4 soils his clothes, therefore the shoes were placed outside to dry. Interview with staff did not reveal how long the transfer chair and shoes were outside.

Interview with the Program Manager (PM) on 2/14/23 revealed client #2's room should have been cleaned after client calmed down from the target behaviors. Continued interview with the PM revealed she was not aware of the paneling being loose on the wall in the hallway. Interview with the PM also revealed she will make sure areas are repaired to ensure clients don't hurt themselves in the hallway especially since several clients have self-injurious (SIBs) and property destruction behaviors. Additional interview with the PM revealed staff should have washed client #4's shoes instead of putting them outside to get wet in the rain.

Subsequent interview with the PM on 2/14/23 revealed the transfer chair belongs to client #6

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W 104	Continued From page 2 and she is not sure why the transfer chair is outside and soiled. Continued interview with the PM verified client #6 has a new transfer chair and the older chair was too small for the client. Interview with the PM also revealed the facility will follow up with the legal guardian to receive approval to discard the transfer chair instead of keeping it outside.	W 104		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy during toileting and personal care for 2 clients (#4, #3). The findings are: Morning observations in the facility on 2/14/23 at 7:05 AM revealed client #4 to enter the bathroom with staff. Continued observations revealed client #4 to pull down his pants and expose his bottom and genitals as the door remained open. Further observations revealed staff to remain in the bathroom while client #4 was toileting. At no point during the observation did staff close the door to ensure client #4 had privacy while toileting. Subsequent observations in the facility on 2/14/23 at 7:30 AM revealed staff to exit client #3's room leaving the door open. Continued observations revealed staff to re-enter client #3's room and resume personal care with the door open and the client's torso exposed as clients and other staff walked pass the door. Further observations	W 130		

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STONERIDGE	222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144

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W 130	Continued From page 3 revealed the door to remain open for approximately 15 minutes as staff continued to provide personal care to client #3 with his torso exposed. Additional observations at 7:45 AM revealed staff to walk past the door and close client #3's door. Interview with the program manager (PM) on 2/14/23 revealed staff have been trained to respect the privacy of the clients. Interview with the PM also revealed client #4 struggles with privacy concerns when toileting. Continued interview with the PM revealed should respect the privacy of all clients during toileting and personal care.	W 130		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to implement specific objectives necessary to meet the needs of 1 of 6 clients (#4). The finding is: Observation in the group home on 2/14/23 at 7:04 AM revealed client #4 to communicate toileting needs to staff. Continued observation revealed client #4 to enter the bathroom with staff, pull down his pants and urinate on the floor. Further observations revealed client #4 to ignore directions from staff to properly use the toilet. Review of client #4's record on 2/14/23 revealed an occupational therapy (OT) evaluation dated	W 227		

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W 227	Continued From page 4 3/1/22. Review of the OT evaluation relative to toileting indicated client #4 requires moderate assistance per staff, client leaves the toilet prior to being finished with urinating and bowel movements on a regular basis, resulting in soiled clothing and toileting accidents. Client does not consistently respond to verbal prompts to remain on the toilet until finished. Client is dependent upon staff for maintaining personal hygiene after toileting. Continued review of client #4's record revealed a nursing evaluation dated 3/28/22 which indicated he is sometimes continent of bladder but does have a hard time getting to the toilet and getting prepared before starting urinating. He will often come to staff holding himself. He will urinate on the floor and around the toilet if he goes without assistance. Interview with the habilitation specialist and facility nurse on 2/14/23 confirmed client #4 has historically displayed minimal toileting skills. Continued interview revealed client #4 has never had a formal training program to address toileting skills.	W 227		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 3 clients (#1, #3, #4). The findings are:	W 436		

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	34G296	A. BUILDING _____ B. WING _____	02/14/2023

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STONERIDGE	222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144

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W 436	Continued From page 5 A. The facility failed to ensure client safety relative to a gait vest for client #4: For example: Observations throughout the survey from 2/13/23-2/14/23 revealed client #4 to pace throughout the facility without a gait vest. Continued observations did not reveal staff to offer client #4 to wear his gait vest to assist with safety during ambulation. Further observations revealed client #4 to have several abrasions to the top of the head and the face below the right eye. Review of the record for client #4 on 2/14/23 reveled a person centered plan (PCP) dated 3/29/22 which indicated the following adaptive equipment: gait vest, bed alarm, transport chair, non-slip soles, high sided dish, shirt protector and bedside hand rail. Continued review of the record for client #4 revealed an OT evaluation dated 3/1/22 which indicated that the client wears a gait vest to assist with ambulation due to falls. Review of the nursing evaluation dated 3/28/22 revealed client #4 wears a gait vest during the day but often repeatedly asks for it to be taken off. Review of an incident report dated 2/11/23 revealed client #4 had a recent fall in the bathroom which resulted in several abrasions to the head and face. Client #4 was assessed by nursing and it was determined that medical treatment was not needed. Interview with staff on 2/14/23 revealed client #4 does not like wear the gait vest. Continued interview with staff revealed client #4 has figured out how to remove the gait vest. Interview with staff also revealed the client is in need of a new gait vest that he can't remove on his own.	W 436		

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W 436	Continued From page 6	W 436		

Interview with the program manager (PM) on 2/14/23 revealed she was not aware that client #4 was taking his gait vest off independently. Continued interview with the PM revealed staff should have offered client #4 the gait vest especially since the client had a recent fall on 2/11/23.

Interview with the facility nurse on 2/14/23 revealed client #4 had a fall on 2/11/23 that resulted in several abrasions. Continued interview with nursing revealed one of the abrasions broke the skin however outside medical treatment was not needed. Further interview with nursing revealed staff were instructed to treat the area with an ointment and it is currently healing. The nurse also revealed during the interview she was not made aware of client #4 taking his gait vest off. Additional interview with the nurse revealed client #4 wears his gait vest at the day program with no problems. Interview with the nurse also revealed staff should have the client's gait vest on during waking hours.

B. The facility failed to provide adaptive equipment for client #3 during mealtimes. For example:

Afternoon observations in the group home on 2/13/23 at 5:55 PM revealed client #3 to participate in the dinner meal. The dinner meal consisted of the following: salmon patty, mashed potatoes, broccoli, 2% milk, water and sugar free beverage. Observations revealed client #3 to use the following adaptive equipment: curved spoon, sippy cup with lid, shirt protector and high sided divided dish.

Continued observations revealed client #3's plate

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W 436	Continued From page 7	W 436		

to slide across the table. Further observations revealed staff to assist client #3 with the remainder of the meal. At no point during the observation did staff provide client #3 a non-skid mat to prevent the plate from slipping.

Morning observations in the group home on 2/14/23 at 7:35 AM revealed client #3 to sit at the dining table and participate in the breakfast meal. The breakfast meal consisted of the following: cheese grits, blueberry muffins, butter, orange juice, milk and water. Continued observations revealed client #3's plate to slide across the table several times. Further observations revealed client #3 to hold his plate with one hand to hold the plate in place to prevent from slipping. At no point during the observation did staff offer client #3 a non-skid mat or rocker knife.

Review of the record for client #3 on 2/14/23 revealed a PCP dated 6/25/22. Continued review of the PCP for client #3 revealed the following diagnoses: I/DD severe, Anxiety Disorder, Mood Disorder, Congenital Cerebral Palsy, spinocerebellar degeneration with paraparesis, hepatitis B carrier, acute and chronic respiratory failure, hypertension, hypertensive cardiovascular disease, obstructive sleep apnea, COPD, arthritis, pneumonia, bowel and bladder incontinence, osteopenia, peripheral vascular disease and dyslipidemia. Further review of the record for client #3 revealed an OT evaluation dated 3/1/22 which indicated that the client uses the following adaptive equipment to assist with hand tremors: nonskid mat and mug with lid or cup with straw. Review of the OT evaluation also recommends client #3 will begin using a weighted spoon and weighted mug with lid.

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W 436	Continued From page 8 Interview with the habilitation specialist and facility nurse on 2/14/23 revealed client #3 should have a nonskid mat to assist with hand tremors and improving independence during mealtimes. Interview with the program manager (PM) on 2/14/23 revealed staff have been trained to provide all adaptive equipment for client #3 during mealtimes. Continued interview with the PM revealed staff should follow client #3's adaptive equipment as prescribed. C. The facility failed to provide adaptive equipment for client #1 during mealtimes. For example: Observations during the survey from 2/13/23-2/14/23 revealed client #1 to sit at the dining table and participate in the dinner and breakfast meals. Observations revealed client #1 to use the following adaptive equipment: maroon spoon, sippy cup with lid, high sided divided dish and platform tray. Observations did not reveal staff to provide client #1 with a nonskid mat as prescribed. Review of the record for client #1 revealed a PCP dated 8/9/22. Continued review of the record for client #1 revealed a nutritional evaluation dated 6/30/22 and PCP dated 8/9/22 which indicated that client #1 has the following adaptive equipment during all meals: high sided divided dish, maroon spoon, cup with lid and straw, meal tray and non-skid mat. Interview with habilitation specialist on 2/14/23 revealed client #1's adaptive equipment order is current. Interview with the facility nurse and program manager (PM) on 2/14/23 revealed staff have been trained to provide client #1 with	W 436		

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	34G296	A. BUILDING _____ B. WING _____	02/14/2023

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W 436	Continued From page 9 adaptive equipment during mealtimes. Continued interview with the PM revealed staff should follow client #1's diet order as prescribed.	W 436		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level of 3 of 6 clients (#4, #5, & #6). The finding is: Observations in the group home on 2/13/23 at 5:50 PM revealed the dinner meal to include salmon patties, broccoli, mashed potatoes, water, and lemonade. Continued observation revealed clients #4, #5, and #6 to consume the dinner meal in whole form. Observations in the group home on 2/14/23 at 6:55 AM revealed the breakfast meal to include grits, muffins, water, and orange juice. Continued observation revealed clients #4, #5, and #6 to consume the muffins in whole form. Further observation 7:01 AM revealed client #4 to consume a second muffin in whole form. Review of records for client #6 on 2/14/23 revealed an occupational therapy evaluation dated 1/5/23 which indicated the client's diet order to be 1-inch consistency. Review of records for client #4 on 2/14/23 revealed a nutritional evaluation dated 2/9/22 which indicated the client's diet order to be ground consistency. Review of records for client #5 on 2/14/23	W 474		

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 _____	02/14/2023

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

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W 474	Continued From page 10 revealed a person-centered plan (PCP) dated 8/30/22 which indicated the client's diet order to be ½-inch consistency with ground meats. Interview with the facility nurse on 2/14/23 verified each client's orders as reviewed are current. Continued interview confirmed staff are responsible for ensuring all clients receive their diet orders as prescribed.	W 474		