STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G256	A. BUILDING ______ B. WING ______	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE RESIDENTIAL	**353 ELM STREET** **FAIR BLUFF, NC 28439**

(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 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 1 of 3 audit clients (#6) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 5/8/23 of client #6's Behavior Support Plan (BSP) dated 8/3/22 revealed target behaviors consisting of agitation, anxious behavior and hallucinations. Further review on 5/8/23 of client #6's BSP revealed no written consent by the HRC. Interview on 5/9//23 with the qualified intellectual disabilities professional (QIDP) revealed that verbal consent was obtained on 3/12/23. However, no written consent has been obtained.	W 262	Written consent from the HRC will be obtained by the QP in addition to the verbal consent which was noted. The QP will ensure written consent is provided when verbal consent is given. This will be reviewed in the HRC to ensure written consent is provided and the QP will follow up and monitor the process of obtaining written consent until it has been received. The QP will follow up after each HRC approval to ensure written consent has been provided.	06/30/23
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#6). The finding is:	W 263	RECEIVED MAY 30 2023 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: QM Director (X6) DATE: 5/19/2023

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 263	Continued From page 1 Review on 5/8/23 of client #6's Behavior Support Plan (BSP) dated 8/3/22 revealed target behaviors consisting of agitation, anxious behavior and hallucinations. The BSP included the use of Escitalopram, Atomoxetine, Trazadone, Clonidine and Chlorpromazine. Further review revealed no consents had been signed by the guardian for these medications. Interview on 5/9/23 with the qualified intellectual disabilities professional (QIDP) revealed written informed consent should have been obtained for Escitalopram, Atomoxetine, Trazadone, Clonidine and Chlorpromazine. The director confirmed no written consent was obtained by the guardian for any medication.	W 263	The QP will obtain consents for the use of the identified medications as required from the guardian. The QP will ensure consents are obtained when required when medications change and/or annually. The Quality Management Department will perform bi-annual reviews to include the review of required consents to ensure future compliance.	06/30/23
W 381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure drugs were stored under secure conditions. The finding is: During observations of medication administration in the home on 5/8/23 at 4:45pm a lock box was noted inside the medication closet unlocked. Immediate interview on 5/8/23 with the medication technician revealed the box inside the medication closet contains controlled medications. The medication technician revealed that the box should be locked at all times and immediately had staff lock it. Interview on 5/9/23 with the facility nurse	W 381	The Program Manager will purchase a new locked box where controlled substances will be stored and the new locked box will be placed inside the medicine cabinet, ensuring the controlled medications are double locked. The Quality Management Department will perform bi-annual reviews to include checking to ensure controlled medications are stored accordingly and are double locked.	06/30/23

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W 381	Continued From page 2 confirmed that all controlled medications should be double locked. Additional interview revealed all controlled medications are required to be kept locked in a secured lock box and then locked inside the medication closet.	W 381		
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 interviews, the facility failed to ensure 1 of 3 audit clients (#6) were taught to use and make informed choices about the use of eyeglasses. The finding is: During observations at the home throughout the survey on 5/8/23 through 5/9/23, client #6 was not wearing eyeglasses. At no time was staff observed encouraging client #6 to put his glasses on. Review on 5/8/23 of client #6's health progress note written on 8/2/22 stated client #6 has myopia and glasses should be worn full time. Interview on 5/9/23 with Staff A revealed client #6 should be wearing his eyeglasses during waking hours and staff should encourage him to put them on. Interview on 5/9/23 with the facility nurse revealed client #6 does have eyeglasses and should be	W 436	Staff will be inserviced on Client #6's specific needs to include wearing glasses at all times by the QP. Staff will prompt Client #6 to wear his glasses at all times. In the event the glasses are damaged and are not wearable, the glasses will be repaired asap. The QP will provide weekly monitoring to ensure staff are prompting Client #6 to wear his glasses and initiate any glass repair needs.	06/30/23

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W 436	Continued From page 3 wearing them while awake. The nurse also confirmed that client #6 should be prompted by staff to put them on if he is not wearing them.	W 436		