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 _____	C 01/17/2024

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W 000	INITIAL COMMENTS A recertification and complaint survey were completed on January 16-17, 2024 for intake #NC00211546. The complaint was unsubstantiated without deficiency.	W 000		
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 record review and interviews, the facility failed to ensure outside services received current individual program plans (IPP) and behavior support plans (BSP) for 4 out of 4 audit clients (#2, #3, #4 and #5). The findings are: A. Review on 1/16/24 of documentation provided at client #2's day program revealed there were no IPP and BSP available. B. Review on 1/16/24 of documentation provided at client #3's day program revealed there were no IPP and BSP available. C. Review on 1/16/24 of documentation provided at client #4's day program revealed the IPP was dated 11/18/15. D. Review on 1/16/24 of documentation provided at client #5's day program revealed the BSP was dated 1/11/19 and the IPP for 12/20/19. Interview on 1/16/24 with Staff B and Staff C revealed they have never received any plans on the clients.	W 120	The QP will locate the applicable IPP's and BSPs and meet with Day Program management to ensure receipt of current plans. The QP will monitor monthly to ensure revised / newly implemented plans are shared with the Day Program. RECEIVED FEB 02 2024 DHSR-MH Licensure Sect	02/29/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Qm Director — (X6) DATE: 1/30/24

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 Interview on 1/16/24 with the Quality Assurance Consultant (QAC) revealed the facility had provided the day program with a large binder of the clients' plans which were supposed to be current. The QAC acknowledged that he could not locate any current plans at the day program and revealed the Qualified Intellectual Disabilities Professional (QIDP) was no longer with the company.	W 120		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure 1 of 4 audit clients (#3) received a continuous active treatment program consisting of needed interventions and services to aide safe transfers and prevent falls as identified in the individual program plan (IPP). The finding is: During observations in the home on 1/16/24 from 11:30 am to 12:30 pm and 3:30 pm until 6:00 pm, client #3 wore slide in "Mule" style house slippers with thin rubber soles. Client #3 ambulated unassisted, with short shuffling of her feet and leaned forward while walking. In addition, client	W 249	The PT will evaluate and implement a program to aide Client #3 with safe transfers and preventing falls. The team will followup with the Orthopedist to assess proper fitting shoes. Pine Ridge staff will be in-serviced on Client #3's transfer and fall prevention program and proper fitting shoes. The QP will monitor weekly to ensure compliance.	03/17/24

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W 249	Continued From page 2 #3 preferred to sit at the end of a leather sofa for most of her activities in the home. The Home Manager (HM) was observed at 4:08 pm, standing on client #3's left side and held her left hand; began a count of 1-2-3 and was pulling on her arm, to get her to stand up. Staff E who was present in the living room area, came over to stand on the right side of client #3, held her right hand, while the HM held the left hand. On the count of 3, client #3 stood up from the couch. Review on 1/17/24 of client #3's IPP revealed it was developed on 2/21/23. The Occupational Therapy Report on 1/24/23 revealed client #3 could sit to stand with moderate assistance and verbal prompts. She was most successful moving from sit to stand given hand placement to push up and rocking x 3 to gain momentum to stand. Further, the Physical Therapy (PT) Quarterly Review on 9/30/23 revealed a recommendation for client #3 to have a normal height and a sofa with arms. Should wear good-fitting shoes ideally with laces and excellent traction that fit or are designed to fit over the heel are ok to wear in the evenings. Review on 1/17/24 of a hospital discharge instructions on 12/11/23 revealed client #3 had fallen at home, had a laceration to head and needed 4 staples to close the wound. There was no report to review the details of the incident. Interview on 1/17/24 with the HM revealed she relied on the former Qualified Intellectual Disabilities Professional (QIDP) to instruct her on transfer guidelines. The HM acknowledged that she was not aware that she was pulling on client #3's arm yesterday when trying to assist her with standing. The HM revealed client #3 had three	W 249		

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W 249	Continued From page 3 open heel house-slippers and preferred to wear them for her shoes. Interview on 1/17/24 with the Quality Assurance Consultant (QAC) revealed client #3's falls have occurred when ambulating not sit to stand transfers. The QAC was aware that orthotic shoes were recommended for client #3 and ordered after her fall last month. The QAC revealed he spoken to the PT who visited the home on 1/13/24 and made recommendations to provide a higher seat. The PT confirmed to the QAC that he had also observed some of the staff pulling on client #3's arms during transfers.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 1 of 4 audit clients (#4) was revised at least annually. The finding is: Review on 1/16/24 of client #4's IPP, dated 3/31/22, revealed no revisions or updates to goals. In addition, updated diet information to change client #4's diet texture from bite-sized to pureed had not been added. The IPP was signed by the Qualified Intellectual Disabilities Professional (QIDP) on 3/31/22 with a hand written date, 3/10/23, added at the top of the second page. Noted doctor appointments were dated for years 2021 and 2022. No formal goals were included in the IPP.	W 260	The QP will review client #4's IPP and update to reflect the proper diet texture. The QP will review / revise all client records monthly and update the IPP as needed to reflect the current habilitation status. Pine Ridge staff will be in-serviced on any planned updates / revisions and the QP will monitor weekly to ensure compliance.	3/17/24

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W 260	Continued From page 4 Review on 1/17/24 of client #4's goal data revealed formal training for bathing, range of motion, and setting his place at the dining table with target dates of 3/31/23. Review on 1/17/24 of client #4's nutritional evaluation, dated 11/7/23, revealed a diet change from bite-sized pieces to pureed. Interview on 1/17/24 with the Quality Assurance Consultant (QAC) revealed client #4's IPP should be updated to include changes in progress and dietary needs annually, or when significant changes are made.	W 260		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varied times throughout the shift. The finding is: Review on 1/16/24 of fire drills revealed monthly drills with shifts designated as first, second, or third. No actual times were recorded for fire drills. Interview on 1/17/24 with the Quality Assurance Coordinator (QAC) revealed the facility should always record the dates on fire drills so that varied times could be determined.	W 441	The EHS Director will train the Program Manager on fire drill process, to include the importance of documenting the date and time of the fire drill. The Program Manager will train all Pine Ridge staff on the fire drill process, to include the importance of documenting data and time of fire drills. The Program Manager will monitor monthly to esure proper documentation of fire drills.	3/17/24
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.	W 454	To prevent cross contamination, the Program Manager will in-service Pine Ridge staff on the handwashing and glove use policy. The Program Manager will monitor weekly to ensure proper handwashing and glove use.	2/29/24

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W 454	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff used proper glove hygiene to prevent cross contamination. This had the potential to effect all clients (#1, #2, #3, #4 and #5) in the home. The finding is: During evening observations in the home on 1/16/24, Staff G was observed to wear gloves and carry a soiled linen to the hallway and place in a hamper. Staff G returned to the kitchen, swept the floor, wiped down the counter tops and placed gloved hands in water in sink basin before discarding his gloves and washing his hands. Review on 1/17/24 of the Infection Control Manual revealed, gloves must be worn when touching surfaces that might be contaminated. Replace disposable gloves as soon as possible if visibly soiled. Interview on 1/17/23 with the Quality Assurance Consultant (QAC) revealed when handling soiled linens, staff should dispose of their gloves afterwards.	W 454		
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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4	W 460	The Program Manager will re-inservice Pine Ridge Staff on client #4's proper food consistency. The Program Manager will observe breakfast and dinner meals twice per week for 2 months to ensure proper food consistency / texture.	2/29/24

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W 460	Continued From page 6 received his specially-modified diet as indicated. This affected 1 of 4 audit clients. The finding is: Observation in the home on 1/16/24 at dinner revealed client #4 was served and consumed a baked potato and a chicken taco. The baked potato was pureed in consistency; the chicken taco was ground texture. On 1/17/24 at breakfast, client #4 was served and consumed two waffles with syrup and eggs without incident. The waffles with syrup were ground texture; the eggs were pureed. Review on 1/17/24 of client #4's nutrition evaluation, dated 11/7/23, revealed his food should be pureed in texture. Interview on 1/17/24 with the home manager revealed the home had pictures of what food textures should be, but staff had not been trained on revised diet plans and textures.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that food was served at the proper temperature for 1 of 4 audit clients (#4) . The finding is: During dinner observations in the home on 1/16/24 at 4:40 pm, Staff F assisted client #4 to process boneless chicken breast, tortilla and baked potato to a puree consistency. The contents of the blender were emptied into two bowls and place on the counter with a paper towel covering it thereafter. Client #4 did not want	W 473	The dietician will in-service all Pine Ridge staff on serving food at the proper temperature. The QP will monitor weekly to ensure all clients are served food at the proper temperature.	2/29/24

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W 473	Continued From page 7 to eat dinner right away and did not come to the table until 5:45 pm. Neither Staff F or the Home Manager (HM) reheated the food for client #4 before transfering the food onto his plate. Client #4 began to eat his food. Interview on 1/16/24 with the HM revealed she did not reheat the food for client #4. Interview with the HM revealed they did not test food temps prior to serving and did not know how to calculate the food temperatures when she tried, per the surveyor's request. The HM acknowledged they did not want to serve the food to the clients hot and would wait 10 minutes for the steam to stop and present it lukewarm.	W 473		