STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G250	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEFIELD HOME	730 FISHER RIDGE DRIVE MONROE, NC 28110

(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 000	INITIAL COMMENTS A complaint survey was completed on 7/22/24 for intake #NC00218622. The allegations for intake #NC00218622 was unsubstantiated and deficiencies were cited.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records, documentation, and interviews, the facility failed to ensure an injury of unknown origin was thoroughly investigated after immediately becoming aware of a reported incident. The finding is: Interview on 7/22/24 with residential manager (RM) revealed that the RM was informed of an injury of unknown origin regarding client #1 on 5/29/24. Continued interview with RM revealed that staff A reported a gash over the left eye of client #1. Staff A reported that it was unknown when the incident occurred. The RM also revealed speaking with staff B to receive a photo of a bruise to the back of client #1's head on the left side. Staff A transported the client to the emergency room (ER). Subsequent interview with the RM revealed that client #1 was evaluated at the ER 5/29/24 with a negative CT scan and a diagnosis of Hematoma of the scalp. Interview on 7/22/24 with the qualified intellectual disabilities professional (QIDP) revealed that an injury of unknown origin occurred on 5/29/24	W 154		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G250	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEFIELD HOME	730 FISHER RIDGE DRIVE MONROE, NC 28110

(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 154	Continued From page 1	W 154		

regarding client #1. Continued interview with QIDP revealed that an internal investigation was not conducted.

Interview on 7/22/24 with the ICF Director verified that the facility did not investigate an injury of unknown origin for the 5/29/24 incident regarding client #1. Continued interview with the ICF Director revealed that the Quality Management department reviews all incidents and decides if the incident meets the criteria to investigate an injury of unknown origin.

Review on 7/22/24 of ER report for client #1 dated 5/29/24 revealed an ER visit for a head injury. Continued review of the report revealed that client #1 was diagnosed with Hematoma of the scalp. The facility did not investigate injury of unknown origin as statements from incident report were inconsistent regarding client #1's injury and the incident occurrence was unknown.

Subsequent review of records on 7/22/24 for client #1 revealed a Person-Centered Plan dated 5/8/24. Continued review of records revealed a diagnosis for the client to have Intellectual Developmental Disabilities (IDD) Severe, Conduct Disorder, Hiatal Hernia, and Seizure Disorder. Further review revealed client #1 ambulates with a wheelchair and is verbal; however, hard to understand due to talking so fast.

Additional review on 7/22/24 of the facility policy and procedure manual regarding the reporting and the conducting of investigations dated 11/17/23. Continued review of policy reveals that the facility is dedicated to providing quality of services and insuring safety and security of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G250	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEFIELD HOME	**730 FISHER RIDGE DRIVE MONROE, NC 28110**

(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 154	Continued From page 2 individuals supported by thoroughly investigating internal and external complaints, injuries of unknown origin, and allegations of abuse, neglect, and exploitation.	W 154		