PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		34G250	B. WING		4.	C I/08/2023
5071018-007-8538-018	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 FISHER RIDGE DRIVE MONROE, NC 28110		100/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	A recertification and complaint survey was completed on November 8, 2023 for intake #NC00207637 and #NC00209550. The complaint allegations were substantiated. Deficiencies were cited, in addition to a condition of participation in the area of active treatment.  ACTIVE TREATMENT SERVICES CFR(s): 483.440  The facility must ensure that specific active treatment services requirements are met.		W 00			
	The facility failed to: as received a continuous which includes aggres implementation of a progeneric training, treatmone related services describing treatment or loss of contents (W196); ensure treatment program continuous and service identified in the person the areas of program in and opportunities for conself-management (W2-person-centered plans at least annually (W26-techniques were monit annually by the human (W262); ensure restricts	active treatment program sive, consistent ogram of specialized and nent, health services and ibed in the subpart, that is evention or deceleration of urrent optimal functional a continuous active asisting of needed ces were implemented as e-centered plan (PCP) in implementation, leisure, hoice and 49); show evidence that were revised and updated (2); ensure that restrictive ored and reviewed rights committee (HRC) ive techniques were d by the legal guardians		DHSR - Mental Health Lic. & Cert. Section		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kevin Clark, Statewide ACF Director

11.30.2023

(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.

77 - 74 - 74 - 74 - 74 - 74 - 74 - 74 -	(X3) DATE SURVEY COMPLETED	
34G250 B WING	C 44/09/2022	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  730 FISHER RIDGE DRIVE  MONROE, NC 28110	11/08/2023	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
Continued From page 1 accomplishment of the criteria specified in the clients' person centered plan objectives was documented in measurable terms to enable quantitative analysis of the client's progress (W252); assure the clients' person centered plan was reviewed by the qualified intellectual disabilities professional (QIDP) and that data was documented as prescribed to assure program objectives were revised as necessary to assure client progress (W257); assure training objectives were developed to meet the client needs as identified by the comprehensive assessment (W227); and assure that adaptive equipment was furnished as prescribed (W438).  The cumulative effect of these systemic practices resulted in the facility's failure to provide statutority mandated active treatment services to its clients.  W 196  ACTIVE TREATMENT CFR(s): 483, 440(a)(1)  Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:  (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.  This STANDARD is not met as evidenced by: Based on record review and interviews, the interdisciplinary team failed to assure that an	n ic d	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		730 F	ET ADDRESS, CITY, STATE, ZIP CODE FISHER RIDGE DRIVE NROE, NC 28110		
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W 196	was provided to 2 of #4). The findings are A. Cross reference was continuous active tree of needed intervention implemented as identification, leist choice and self-managements (#2).  B. Cross reference was clients (#2).  B. Cross reference was clients (#2).  C. Cross reference was client's progress for 2 and #4).  C. Cross reference was client's progress for 2 and #4).  C. Cross reference was client's progress for 2 and #4).  C. Cross reference was client's progressional and that documented as preson ceby the qualified inteller professional and that documented as preson ceby the qualified inteller professional and that documented as preson ceby the qualified inteller professional and that documented as preson ceessary relative to sampled clients (#2 and prevised and updated clients (#2).  E. Cross reference was reference was reference was reference was reference was reference was reference that restrictive	at active treatment program 3 sampled clients (#2 and a: W249. The facility ensure a partment program consisting ons and services were stified in the person-centered as of program are, and opportunities for agement for 1 of 3 sampled w252. The facility failed to be accomplishment of the declient person centered accomplishment of the election person centered plants were reviewed accomplished to assure revisions as client progress for 2 of 3 and #4).  W260. The facility failed to person-centered plans were at least annually for 1 of 3	W 196	This page is intentionally left blank.		
	and reviewed annuall	y by the human rights 6 of 6 clients (#1, #2, #3,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		730	REET ADDRESS, CITY, STATE, ZIP CODE FISHER RIDGE DRIVE NROE, NC 28110		1100/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	F. Cross reference ensure restrictive to approved by the leg (#1, #2, #3, #4, #5, G. Cross reference ensure training objective meet the needs idea assessment for 1 of the consument of the consu	W263. The facility failed to echniques were reviewed and gal guardians for 6 of 6 clients and #6).  W227. The facility failed to ectives were developed to nitified by the comprehensive if 3 sampled clients (#2).  W436. The facility failed to equipment was furnished as a sampled clients (#2).  RAM PLAN  4)  am plan states the specific by to meet the client's needs, comprehensive assessment on (c)(3) of this section.  not met as evidenced by: in, record review and failed to assure the person included training objectives eeds for 1 of 3 sampled ling is:  and in the group home on everally it was time to prepare for servation at 4:50 PM sit at the dining table and ent to complete the following e, choose and pour her drink	dev clie to r dev ICF Upd train train ICF		olan for g objectives and will roal.  staff on the an and t #2.  Residential g personinclude heir needs.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
	Target Date: 12/22/2023	

PRINTED: 11/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	two cups with lids. PM revealed staff to place her dishes in kitchen.  Morning observation revealed staff B to ptime for the breakfas observation at 6:58 client #2 to the dinin breakfast meal. Further evealed staff B to solient #2 and prompfollowing tasks: chooplate, and pour her client #2 and prompfollowing tasks: chooplate, and pour her client #2 and prompfollowing tasks: chooplate, and pour her client #3 AM-7:45 AM revealed independently using two cups with lids, diand a towel to hold to the record dated 8/1/20. Conting PCP revealed the following to command the record dated 8/1/20. Conting PCP revealed the following her head (yet board; point to commactivities. Review of following adaptive ed spouted cup with har curved weighted sposhower chair, bedraid splint and bunny boots were us extremity circulation.	Additional observation at 5:50 overbally prompt client #2 to a basket to be taken to the ans on 11/8/23 at 6:50 AM or ompt client #2 that it was st meal. Continued AM revealed staff to transition g table to participate in the ther observation at 7:00 AM it at the dining table with the client to complete the obse her food items, make her drink with hand over hand all observations from 7:15 and client #2 to eat a curved weighted spoon, vider plate, shirt protector, the plate in place.  If or client #2 revealed a PCP mued review of the 8/1/20 and lower to activity by eas); use a communication	W 227	This page is intentionally	left blank.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
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	ELD HOME		730	EET ADDRESS, CITY, STATE, ZIP CODE FISHER RIDGE DRIVE NROE, NC 28110		
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W 227	objectives or update Interview with the indisabilities profession revealed communicate am reviews, and located beyond 8/1 Interview with the inter	nterim qualified intellectual ional (QIDP) on 11/8/23 cation objectives, QIDP notes, plan updates could not be /20 during the survey.  Interim QIDP and staff C are not aware of client #2's gram to be implemented to f independence. Further interim QIDP revealed that revisions, and/or updates ication for client #2 should be	W 227			
W 249	CFR(s): 483.440(d) As soon as the interformulated a client's each client must rectreatment program conterventions and seand frequency to sur		dev clie to 1 dev ICI upo trai	e interdisciplinary team welop a person-centered plant #2, to include training meet the client's needs, and relop a making choices go.  F Director will retrain all stated person-centered plant ining objectives for client #	an for objectives d will al. taff on the and #2.	
	Based on observation review, the facility far active treatment projections and selectified in the personal the areas of program and opportunities for	not met as evidenced by: ons, interview and record iled to ensure a continuous gram consisting of needed rvices were implemented as on-centered plan (PCP) in in implementation, leisure, choice and 1 of 3 sampled clients (#2).	cen trai ICF Pee elec	am Leaders on developing tered plans for clients, to i ning objectives to meet the Director will follow Mon r Review schedule to mon stronic medical records.  get Date: 12/22/2023	nclude eir needs.	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			ATE SURVEY DMPLETED		
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		34G250	B. WING			11/08/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 730 FISHER RIDGE DRIVE MONROE, NC 28110	E, ZIP CODE	
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	The finding is:  Observations throug survey in the group participate in mealtin administration. Con reveal client #2 to be training or integrative observation period.  Review of the record revealed a PCP date of the 8/2020 PCP reincrease her overall enjoys listening to the looking at magazine: neighborhood, and lia a recliner.  Subsequent review of staff should ask the of questions and/or use the client choose from review of the 8/2020 program objectives: with her finger, tolerate collage, toothbrushin and point to communishe wants to participathroughout the day. The reveal PCP revisions of the staff should ask the objectives: with her finger, tolerate collage, toothbrushin and point to communishe wants to participathroughout the day. The reveal PCP revisions of the staff should the day in the staff should ask	ghout the 11/7/23 - 11/8/23 home revealed client #2 to mes and medication tinued observations did not e engaged in any other formal e activities throughout the  d for client #2 on 11/8/23 ed 8/1/20. Continued review evealed client #2 would like to level of independence, he radio, watching television, s, going for a stroll in the eikes to draw while relaxing in  of the 8/1/20 PCP indicated client a yes/no related e pictures of options and have m the items. Continued PCP indicated the following make choices by pointing ate a manicure, make a ng goal, use her picture board hicate to staff what activity ate in as assigned Review of the record did not	W	This page is into	entionally left blank	

HT GTA 1. (2017) 및 GTA 1. (2017)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	TIPLE CONSTRUCTION		SURVEY
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W 249	could not be located interview with the interview with the interview updated as should have updated objectives as require	during the survey. Further erim QIDP verified that client ated and revised training ed.	W 249			
VV 202	CFR(s): 483.440(e)( Data relative to acco specified in client ind	1) mplishment of the criteria	VV 232	A. Program documentation for individuals will include date relative to the accomplish of the criteria specified in individual program plan a objectives will be docume measurable terms.	include data ecomplishment ecified in client am plan and e documented in	
	Based on record revi failed to assure data the accomplishment the person centered documented in meas	not met as evidenced by: ew and interview, the facility was retrieved to determine of the objectives specified in plan (PCP) was adequately urable terms for 2 of 3 and #4). The findings are:		B. Program data for all indiv will be collected and documented for program objectives and behavior strategies.	riduals	
	the PCP was docume example: Review of the record revealed a PCP date and service objective: record for client #2 die	o ensure that data relative to ented for client #2. For for client #2 on 11/8/23 d 8/1/20 with six program s. Continued review of the d not reveal a PCP with or 2021, 2022 and 2023.		ICF Director will retrain all Residential Team Leaders that al clients should receive continuous QIDP data reviews to determine progress towards training and behavior objectives.		
	not reveal PCP prograteam meeting notes, determine the client's training objectives tow			ICF Director will retrain direct supstaff on completing measurable documentation of services.  ICF Director will follow Monarch Peer Review schedule to monitor of	`s	

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	electronic medical records.	
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		34G250	B WING			C	
	PROVIDER OR SUPPLIER		730 F	EET ADDRESS, CITY, STATE, ZIP CODE FISHER RIDGE DRIVE IROE, NC 28110		1/08/2023	
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W 252	reveal evidence of the QIDP quarterly revial approve, update, and for 2021, 2022 and to assure treatment in measurable terms 2023 as part of a coprogram.  Interview with the indisabilities profession program goals and on the following years: Continued interview revealed the previous role on 10/23/23. Further QIDP revealed training objectives a program data at least B. The facility failed collected and document and behavior strategiexample:	treatment team meetings, ews or team signatures to and implement program goals 2023. The facility also failed objectives were documented in for 2020, 2021, 2022 and intinuous active treatment active treatment and (QIDP) revealed that the objectives for client #2 could the 11/7/23-11/8/23 survey for 2021, 2022, and 2023. With the interim QIDP us QIDP was relieved of her or interview with the end that all clients should have and documented updates on strength and the control of the c	W 252	This page is intentionally left bla	ink.		
	revealed a behavior which indicated the f severe disruption, in aggression. Further #4 did not reveal behavior objectives since 10/1 Subsequent review of the severe determine the accomplexities and the severe since 10/1 subsequent review of the severe determine the accomplexities and the severe	plishment of behavior					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
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NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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				MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)	DBE	(X5) COMPLETION DATE
W 252	evaluated and treate	d in the emergency room	W 25	52		
	Review of the record	relative to head banging. for client #4 did not reveal ors (SIBs) or head banging				
	revealed that behavior could not be located of interview with the interprevious QIDP was really a support of the previous QIDP was really a support of the previous QIDP reviews to determining and behavior PROGRAM MONITO CFR(s): 483.440(f)(1)  The individual programal least by the qualified of professional and revision to the professional and revision to the professional and revision failing to progress town after reasonable effort. This STANDARD is not be a support of the programment	should receive continuous rmine progress towards objectives.  RING & CHANGE (iii)  Implan must be reviewed at mental retardation sed as necessary, including, ations in which the client is rard identified objectives as have been made. The total mental retrieves, the team atta for 2 of 3 sampled are collected and ribed for program objectives antered plan (PCP) to the session. The finding is:  The finding is:  The finding is:	W 25	All individual program plans was reviewed by the QP and revised necessary, including, but not lin situations in which the client is to progress toward identified ob after reasonable efforts have been ICF Director will retrain all Rest Team Leaders on reviewing and revising person centered plans a necessary, including, but not lim situations in which the client is to progress toward identified ob after reasonable efforts have been ICF Director will follow Monard Peer Review schedule to monito electronic medical records.	as nited to failing niectives en made. sidential l as nited to failing jectives en made.	
	Review of the record for	or client #2 on 11/8/23		Target Date: 12/22/2023		

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W 257	revealed a PCP da following program is board and point to activities; toothbrus make a collage and her head; and toler review of the 8/1/20 review or assessmilisted in the plan to Further review of the reveal program or sfor the following year Additional review or not reveal QIDP as since 8/1/20.  Review of the recorrevealed a PCP data following program of administration goal common area after goal and building by record revealed a become administration for yelling/screaming a aggression; and used device. Continued for client #4 did not behavior data of traplan to determine client #4 did not behavior data of traplan to determine client PCP also did not revere pCP until 10/18/23.  Interview with the indisabilities profession.	ted 8/1/20 which indicated the goals: use a communication communicate to choose sh goal; handwashing goal; d agree to activity by shaking ate a manicure. Continued D PCP did not reveal team ents of program objectives determine client progression. He record for client #2 did not service objectives for client #2 ars: 2021, 2022, and 2023. If the record for client #2 did sessments or team review and for client #4 on 11/8/23 ared 1/3/23 which indicated the	W 257	This page is intentionally	y left blank.	

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LD HOME			MONROE, NC 28110		
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client #2 could not be located during the survey. Interview with the interim QIDP also revealed that review of behavior data and training objectives were not found for client #4 during the survey. Continued interview with the interim QIDP revealed that the previous QIDP was relieved of their duties on 10/23/23. Further interview with the interim QIDP also revealed that training objectives have been ongoing for client #2 since 8/1/20 with no revisions. Interview with the interim QIDP also revealed that staff were implementing training objectives for both clients #2 and #4 with no team or guardian review and signatures.  Subsequent interview with the interim QIDP revealed that the QIDP is responsible for collecting and documenting data relative to program and services objectives regularly. Interview with the interim QIDP verified the lack of data collection for all objectives prevented the ability to review the clients (#2, #4) progression or regression and revise as necessary.  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 review and interview, the facility failed to show evidence that person-centered plans were revised and updated at least annually for 1 of 3 sampled clients (#2). The finding is:		W 25	7		
			revised at least annually and documented within the clients recording of the process of interdisciplinary to notes relative to PCP meetings or revisions.  ICF Director will retrain all Reside Team Leaders that at least annually	ential y, all	
	Continued From pag client #2 could not be Interview with the interim QIDP also reviewed and #4 with no revision interview with the interim QIDP also reviewed that the QID collecting and docum program and services Interview with the interim QIDP also reviewed that the QID collecting and docum program and services Interview with the interim QIDP also reviewed that the QID collecting and docum program and services Interview with the interimedata collection for all ability to review the claregression and revise PROGRAM MONITO CFR(s): 483.440(f)(2)  At least annually, the must be revised, as a process set forth in particular and the process forth in particula	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G250  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11 client #2 could not be located during the survey. Interview with the interim QIDP also revealed that review of behavior data and training objectives were not found for client #4 during the survey. Continued interview with the interim QIDP revealed that the previous QIDP was relieved of their duties on 10/23/23. Further interview with the interim QIDP also revealed that training objectives have been ongoing for client #2 since 8/1/20 with no revisions. Interview with the interim QIDP also revealed that staff were implementing training objectives for both clients #2 and #4 with no team or guardian review and signatures.  Subsequent interview with the interim QIDP revealed that the QIDP is responsible for collecting and documenting data relative to program and services objectives regularly. Interview with the interim QIDP verified the lack of data collection for all objectives prevented the ability to review the clients (#2, #4) progression or regression and revise as necessary. 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 review and interview, the facility failed to show evidence that person-centered plans were revised and updated at least annually	CONTINUED FOR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  Client #2 could not be located during the survey. Interview with the interim QIDP also revealed that review of behavior data and training objectives were not found for client #4 during the survey. Continued interview with the interim QIDP was relieved of their duties on 10/23/23. Further interview with the interim QIDP revealed that the previous QIDP was relieved of their duties on 10/23/23. Further interview with the interim QIDP also revealed that training objectives have been ongoing for client #2 since 8/1/20 with no revisions. Interview with the interim QIDP also revealed that staff were implementing training objectives for both clients #2 and #4 with no team or guardian review and signatures.  Subsequent interview with the interim QIDP revealed that the QIDP is responsible for collecting and documenting data relative to program and services objectives regularly. Interview with the interim QIDP verified the lack of data collection for all objectives prevented the ability to review the clients (#2, #4) progression or regression and revise as necessary.  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 review and interview, the facility failed to show evidence that person-centered plans were revised and updated at least annually for 1 of 3 sampled clients (#2). The finding is:	DEPERCIENCIES  1 A SULIDING  1 SUMMARY STATEMENT OF DEFICIENCIES (ICACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  Client #2 could not be located during the survey. Interview with the interim QIDP also revealed that review of behavior data and training objectives were not found for client #4 during the survey. Continued Interview with the interim QIDP revealed that the previous QIDP also revealed that training objectives have been ongoing for client #2 since 81/120 with no revisions. Interview with the interview with the interim QIDP revealed that training objectives have been ongoing for client #2 since 81/120 with no revisions. Interview and signatures.  Subsequent interview with the interim QIDP revealed that training objectives have been ongoing for client #2 since 81/120 with no revisions. Interview and signatures.  Subsequent of the interview with the interim QIDP revealed that training objectives prevented the ability to review the clients (#2, #4) progression or regression and revise as necessary.  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 review and interview, the facility failed to show evidence that person-centered plans were revised and updated at least annually for 1 of 3 sampled clients (#2). The finding is:  Review on 11/8/23 of client #22's record revealed a Decord revealed a Decord revealed and Decord revealed and Decord revised and updated at least annually Person-Centered Plans will be revised.	DOT   DOT TO SUPPLY

EPARTMENT OF HEALTH AND HUMAN SER ENTERS FOR MEDICARE & MEDICAID SER	FORM OMB NO.	APPROVE . 0938-039
	ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records.	
	Target completion date: 12/22/2023	

PRINTED: 11/20/2023

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G250	B WING		1	C 1/08/2023
	ROVIDER OR SUPPLIER		730	EET ADDRESS, CITY, STATE, ZIP CODE FISHER RIDGE DRIVE NROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 260	intellectual disabilition interdisciplinary meetings or revisio client #2 did not revand 2023 review years.	les professional (QIDP) notes, team notes relative to PCP ns. Review of the record for yeal PCPs for the 2021, 2022, pars.	W 260			
W 262	revealed that the cu not be located durir interview with the in plan team meetings completed. Interview verified that all clier reviews at least and	ORING & CHANGE	W 262	CF Director will complete	,	
	The committee sho monitor individual p inappropriate behavin the opinion of the client protection and This STANDARD is Based on observati interview, the facility restrictive technique reviewed annually b (HRC) for 6 of 6 clie #6). The finding is:  Observations throughout 11/7/23-11/8/2	uld review, approve, and rograms designed to manage vior and other programs that, committee, involve risks to	pr fre cli de be in in an	esent, and obtain written om the HRC committee for the HRC committee for ients for any program that esigned to manage inapprochavior and other program the opinion of the committee of risks to client prote and rights.  CF Director will retrain all tesidential Team Leaders east annually, the RTL will btain written consent from	consent or all 6 t is opriate as that, ittee, oction	
	observation reveale staff and clients ent Subsequent review	the door to chime loudly as ered and exited the facility.  throughout the recertification oor alarm on client #5's	to	or any program that is deso o manage inappropriate be nd other programs that, in pinion of the committee,	ehavior the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES	risks to client protection and	
	rights.	
	ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records.	
	Target completion date: 12/22/2023	

PRINTED: 11/20/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391
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PRINTED: 11/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		34G250	B. WING		1	C 1/08/2023	
	ROVIDER OR SUPPLIER		730 F	ET ADDRESS, CITY, STATE, ZIP CODE ISHER RIDGE DRIVE IROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
W 262	bedroom door. Of bedroom door alar entered and exited. Review of the recoperson centered p Continued review behavior support p 6/9/23. Further review of the following targe proper staff superson beverages not sand disrobing; dan furniture; self-injuriflushing items down Review of facility donot reveal current flimitation consents and #6. Continued documentation did alarms to be used a interventions for the Interview with staff the exterior door all from AWOL from the interview with staff requires close super behaviors in additional littles profession revealed human rigexterior and bedrood completed for the cowith the interim QID are used as a behavior	poservation also revealed the rm to chime loudly as the client of his bedroom.  Ford for client #5 revealed a stan (PCP) dated 8/22/23.  For the record revealed a solan (BSP) for client #5 dated view of the 6/9/23 bsp indicated to behaviors: AWOL without vision; elopement; taking food served to him; exposing himself maging his clothing; jumping on ous behaviors (SIBs); and in the toilet.  For clients #1, #2, #3, #4, #5 or clients #1, #2, #3, #4, #5 or creat door chimes or as behavior support	W 262	This page is intentionally left bla	ank.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G250	B. WING		C 11/08/2023	
	ROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 230 FISHER RIDGE DRIVE MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
W 262 W 263	interview with the i although exterior client #5, HRC limit all clients (#1, #2, # restrictive technique PROGRAM MONIT	nterim QIDP revealed that oor alarms are required for lation consents are required for \$3, #4, #5, and #6) as the less affects all clients.  FORING & CHANGE	W 262 W 263	ICF Director will complete,		
	are conducted only consent of the clier minor) or legal gua This STANDARD is Based on observat interviews, the facilitechniques were re legal guardians for #5 and #6) relative finding is:  Observations through from 11/7/23-11/8/2 alarms on exit door observation revealed staff and clients entirely survey revealed a consensuration door. Observation door alarm entered and exited  Review of facility do not reveal guardian alarms for clients #Review of the beha 6/9/23 for client #5 alarm is to be used	auld insure that these programs with the written informed at, parents (if the client is a rdian. It is not met as evidenced by: ions, record review and ity failed to ensure restrictive viewed and approved by the 6 of 6 clients (#1, #2, #3, #4, to exterior door alarms. The ghout the recertification survey 23 revealed exterior door s of the facility. Continued at the door to chime loudly as tered and exited the facility.  Throughout the recertification door alarm on client #5's servation also revealed the in to chime loudly as the client		present, and obtain written consent from the legal guardians for all 6 clients for any program that is designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  ICF Director will retrain all Residential Team Leaders that at least annually, the RTL will obtain written consent from legal guardians for any program that is designed to manage inappropriate behavior and other programs that in the opinion of the committee, involve risks to client protection and rights.  ICF Director will follow Monarch Peer Review schedule to monitor electronic medical records.  Target completion date: 12/22/202	l s e e t,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A BUILDING	(X3) DATE SURVEY COMPLETED		
		34G250	B. WING		C 11/08	/2023
	PROVIDER OR SUPPLIER		730	REET ADDRESS, CITY, STATE, ZIP CODE DISHER RIDGE DRIVE DINROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE (	(X5) COMPLETION DATE
W 263	the record for client consent for the extra alarms.  Interview with the indisabilities profess revealed guardian bedroom door alart collected for the clienthe interim QIDP verified that guardian consett interventions af #5, guardian consett interventions af #5, and #6). Addition QIDP verified that guardian consett interventions af #5, and #6). Addition QIDP verified that guardian consett interventions af #5, and #6). Addition QIDP verified that guardian consett interventions af #5, and #6). Addition NURSING SERVIC CFR(s): 483.460(c).  Nursing services mother members of the propriate protect measures that included the propriate protect in the p	nterior door and bedroom door  Interior door and bedroom door  Interior door and bedroom door  Interior qualified intellectual  Interior qualified intellectual  Interior and the start of the exterior and  Interior and the exterior and  Interior all client as  Interior and the interior  Interior and the interior and  Interior and the interior and  Interio	as IC or	CF Director obtained updated diesessment for client #2 on 11/27/CF Director trained all direct care updated dietary assessment for 2 on 11/28/2023.	2023. e staff	
	health and hygiene This STANDARD is Based on record re- services failed to er assessment was im clients (#2). The fin  Review of the recor revealed a nutritional Continued review of	s not met as evidenced by: view and interviews, nursing nsure the updated dietary plemented for 1 of 3 sampled	Ro di tir IC Pe ele	CF Director will train LPN and esidential Manager on ensuring tetary assessments are implementately or when prescribed.  CF Director will follow Monarcher Review schedule to monitor dectronic medical records.  Arget Completion Date: 12/22/20	's client	

conflicted and an area		UMEDIO/ID OLIVIOLO	T		(X3) DATE SUF	D. 1877. 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		
		34G250	B. WING		11/08/	2023
	ROVIDER OR SUPPLIER	***************************************	730 F	ET ADDRESS, CITY, STATE, ZIP CODE ISHER RIDGE DRIVE IROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 340	diet: regular, mois stews and casserd in the AM; one can mixed in food; sect with handle. Addin supplement PO twinutritional assessmeight has been dictient's BMI indicat. The client is unable Boost Plus supplement Polymer Plus supplement Polymer Plus supplement Plus sup	at with ground meat except ble; high calorie prune mixture is soda per day, flax seeds tional plate and spouted cuping Boost Plus or similar ice daily. Further review of the ment indicated that the client's own in the last quarter and the less that she is underweight. The togain weight despite getting ments twice daily.  1023 medication administration 10/24/23 physician's order did not #2 would receive high calorie e AM. Review of nurses' notes 23 did not reveal information changes for the client.  1024 aware of the diet changes nued interview with nursing by protocol is for facility scuss the changes with the lift schedule an appointment re physician to ensure that the died to the physician's order, a trained on client #2's	W 340	This page is intentionally left h	plank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		34G250				C C
NAME OF D	ROVIDER OR SUPPLIER	34G250	B.WING	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	08/2023
	LD HOME		7	30 FISHER RIDGE DRIVE MONROE, NC 28110		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
W 340	Continued From page	ne 17	W 340			
		nt and staff should follow all				
W 436	SPACE AND EQUIP		W 436			
	CFR(s): 483.470(g)			A. The facility will ensure		
	and teach clients to choices about the use hearing and other countries and other countries and other devices id interdisciplinary tear. This STANDARD is Based on observation interview, the facility equipment was furnis sampled clients (#2).  A. The facility failed equipment was repart was repart and the equipment was repart and the e	n as needed by the client. not met as evidenced by: ons, record review and failed to assure that adaptive shed as prescribed for 1 of 3 . The findings are: to ensure that adaptive ired and functional for client elchair. For example: shout the survey from ealed client #2 to sit in a		adaptive equipment for is in good repair and fur OT and National Seat M came out to assess the wheelchair to review the of replacing or repairing equipment.  B. ICF Director obtained up OT assessment for client trained all staff on updat assessment to reflect the implementation of Dyce on 11/28/2023.  ICF Director will retrain all Ref.	e option the pdated t #2 and ed m mat	
	assistance. Continu wheelchair to have a and wood that obtrue	air and to ambulate with staff ed observations revealed the a piece of exposed padding ded into client #2's right side. on 11/8/23 at 8:00 AM		Team Leaders and direct care st Ridgefield Group Home on documentation of adaptive equipole checklist.		
		or to alert staff that the				
	exposed piece of wo	od was missing a covering	1	ICF Director will follow Monar		
		the client's right side.		Peer Review schedule to monitor	r client	
		evealed the staff to take a exposed piece of wood.		electronic medical records.		
	dated 8/1/20. Continuous client #2 revealed an	for client #2 revealed a PCP nued review of the record for incomplete adaptive checklist. Further review of		Target completion date: 12/22/2	023	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G250			(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED		
		B WING		C 11/08/2023		
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	11100/2020	
			730 F	TISHER RIDGE DRIVE		
RIDGEFIE	LD HOME		MOR	IROE, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
	Continued From page 18 the adaptive equipment monthly checklist did not reveal the need for repairs for client #2's wheelchair. Additional review of the record did not reveal a monthly adaptive equipment checklist.  Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/8/23 revealed that the facility has started completing adaptive equipment checklists monthly for all clients with wheelchairs. Continued interview with the interim QIDP revealed that he was not aware that client #2's wheelchair needed repairs. Further interview with the interim QIDP revealed that once the adaptive equipment checklist is completed, then an assigned staff member will review the checklists weekly and submit work orders for wheelchair repairs or replacement parts. Additional interview with the interim QIDP revealed that all clients should have functional adaptive equipment.  B. The facility failed to ensure that adaptive equipment was available for client #2 during mealtimes. For example:  Afternoon observations on 11/7/23 from 4:45 PM - 6:00 PM revealed client #2 to sit at the dining table and participate in the dinner meal.  Continued observation at 5:10 PM revealed client #2 to eat independently using a curved coated weighted spoon, shirt protector, high sided dish, and two handled cups with lids. Further observation revealed client #2 to eat		W 436	This page is intentionally left blank.		

010111	TOT OTT MEDIONICE	WIND OF WICE			OIVID	VU. U930-U39 I	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G250			B. WING				
NAME OF F	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1	1/08/2023	
RIDGEFIE	ELD HOME			ISHER RIDGE DRIVE			
- NOOLI II	- CO TIONE		MON	IROE, NC 28110			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLETION		
W 436	Continued From page 19 Morning observations on 11/8/23 from 6:55 AM to 7:35 AM revealed client #2 to sit at the dining		W 436	This page is intentionally left blank.			
	to slide as she ate observation at 7:20 towel under client # sliding. At no point	te in the breakfast meal. tions revealed client #2's plate independently. Further AM revealed staff to place a telescopic plate to prevent it from during the observation did mat under the plate to ng forward.					
	revealed a PCP dat client #2 would like independence. Con PCP revealed that of following adaptive e sectional plate; spormat, modified utens Review of the nutriti 9/29/23 revealed cliindependently. Cont client #2 revealed assessment dated 5 following adaptive e bedrails, wheelchair of the 5/22/23 OT as	ed for client #2 on 11/8/23 ed 8/1/20 which indicated that to increase her overall level of tinued review of the 8/2020 client #2 should use the equipment during mealtimes: uted cup with handles, dycem ils and clothes protector. onal assessment dated ent #2 is able to feed herself tinued review of the record for in occupational therapy (OT) is/22/23 which listed the quipment: hospital bed, and mechanical lift. Review issessment did not reveal client #2 should use during					
	client #2 eats well in interview with staff C had a dycem mat to independence during the interim QIDP on not aware if client #2 dycem mat during m	c on 11/8/23 revealed that dependently. Continued crevealed client #2 has not improve her level of gmealtimes. Interview with 11/8/23 revealed that he is has previously used a ealtimes. Continued erim QIDP revealed that he					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C 11/08/2023	
		34G250					
NAME OF PROVIDER OR SUPPLIER  RIDGEFIELD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  730 FISHER RIDGE DRIVE  MONROE, NC 28110				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
W 436	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		WA	This p	page is intentionally left bland	K.	