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 11/08/2023

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 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.	W 000		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: assure that each client received 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 the subpart, that is directed toward the prevention or deceleration of regression or loss of current optimal functional status (W196); ensure a continuous active treatment program consisting of needed interventions and services were implemented as identified in the person-centered plan (PCP) in the areas of program implementation, leisure, and opportunities for choice and self-management (W249); show evidence that person-centered plans were revised and updated at least annually (W260); ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) (W262); ensure restrictive techniques were reviewed and approved by the legal guardians (W263); assure data relative to the	W 195	W195 ICF Director will ensure that each client receives a specific active treatment service, and that requirements are met. Target Date: 12/22/2023 DHSR - Mental Health Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kevin Clark, Statewide ICF Director — TITLE — (X6) DATE: 11.30.2023

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 195	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 (W436). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to its clients.	W 195		
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	W196 W 196	Client #2 and Client #4 will have consistent active treatment program each client will have a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. ICF Director will retrain all Residential Team Leaders on W196. ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records. Target Date: 12/22/2023	

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W 196	Continued From page 2 aggressive consistent active treatment program was provided to 2 of 3 sampled clients (#2 and #4). The findings are: A. Cross reference W249. The facility ensure a continuous active treatment program consisting of needed interventions and services were implemented as identified in the person-centered plan (PCP) in the areas of program implementation, leisure, and opportunities for choice and self-management for 1 of 3 sampled clients (#2). B. Cross reference W252. The facility failed to ensure data relative to accomplishment of the criteria specified in the client person centered plan objectives was documented in measurable terms to enable quantitative analysis of the client's progress for 2 of 3 sampled clients (#2 and #4). C. Cross reference W257. The facility failed to ensure the person centered plans were reviewed by the qualified intellectual disabilities professional and that objective data was documented as prescribed to assure revisions as necessary relative to client progress for 2 of 3 sampled clients (#2 and #4). D. Cross reference W260. The facility failed to show evidence that person-centered plans were revised and updated at least annually for 1 of 3 clients (#2). E. Cross reference W262. The facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4, #5, and #6).	W 196	This page is intentionally left blank.	

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W 196	Continued From page 3 F. Cross reference W263. The facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 6 of 6 clients (#1, #2, #3, #4, #5, and #6). G. Cross reference W227. The facility failed to ensure training objectives were developed to meet the needs identified by the comprehensive assessment for 1 of 3 sampled clients (#2). H. Cross reference W436. The facility failed to ensure that adaptive equipment was furnished as prescribed for 1 of 3 sampled clients (#2).	W 196		
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 observation, record review and interview, the facility failed to assure the person centered plan (PCP) included training objectives to meet the client's needs for 1 of 3 sampled clients (#2). The finding is: Afternoon observations in the group home on 11/7/23 at 4:45 PM revealed staff E to verbally prompt client #2 that it was time to prepare for dinner. Continued observation at 4:50 PM revealed client #2 to sit at the dining table and staff to prompt the client to complete the following tasks: make her plate, choose and pour her drink with hand-over-hand assistance. Further observation from 5:00 PM - 5:50 PM revealed client #2 to eat independently using a curved	W 227	W227 The interdisciplinary team will meet to develop a person-centered plan for client #2, to include training objectives to meet the client's needs, and will develop a communication goal. ICF Director will retrain all staff on the updated person-centered plan and training objectives for client #2. ICF Director will retrain all Residential Team Leaders on developing person-centered plans for clients, to include training objectives to meet their needs. ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records.	

			Target Date: 12/22/2023	

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W 227	Continued From page 4 weighted spoon, divided plate, shirt protector, and two cups with lids. Additional observation at 5:50 PM revealed staff to verbally prompt client #2 to place her dishes in a basket to be taken to the kitchen. Morning observations on 11/8/23 at 6:50 AM revealed staff B to prompt client #2 that it was time for the breakfast meal. Continued observation at 6:58 AM revealed staff to transition client #2 to the dining table to participate in the breakfast meal. Further observation at 7:00 AM revealed staff B to sit at the dining table with client #2 and prompt the client to complete the following tasks: choose her food items, make her plate, and pour her drink with hand over hand assistance. Additional observations from 7:15 AM-7:45 AM revealed client #2 to eat independently using a curved weighted spoon, two cups with lids, divider plate, shirt protector, and a towel to hold the plate in place. Review of the record for client #2 revealed a PCP dated 8/1/20. Continued review of the 8/1/20 PCP revealed the following program goals: toothbrush goal; handwashing goal; tolerate a manicure; make a collage; agree to activity by shaking her head (yes); use a communication board; point to communicate and choose activities. Review of the 8/1/20 also revealed the following adaptive equipment: sectional plate, spouted cup with handle, dycem mat, wheelchair, curved weighted spoon, clothing protector, shower chair, bedrails, adult briefs, left hand wrist splint and bunny boots to both wear at night. Further review of the 8/1/20 PCP revealed the bunny boots were used at night to aid in lower extremity circulation. Subsequent review of the record for client #2 did not reveal communication	W 227	This page is intentionally left blank.	

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W 227	Continued From page 5 objectives or updates since 8/1/20. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/8/23 revealed communication objectives, QIDP notes, team reviews, and plan updates could not be located beyond 8/1/20 during the survey. Interview with the interim QIDP and staff C revealed that staff are not aware of client #2's communication program to be implemented to improve her level of independence. Further interview with the interim QIDP revealed that training objectives, revisions, and/or updates relative to communication for client #2 should be completed as required.	W 227		
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, interview and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions and services were implemented as identified in the person-centered plan (PCP) in the areas of program implementation, leisure, and opportunities for choice and self-management for 1 of 3 sampled clients (#2).	W 249	The interdisciplinary team will meet to develop a person-centered plan for client #2, to include training objectives to meet the client's needs, and will develop a making choices goal. ICF Director will retrain all staff on the updated person-centered plan and training objectives for client #2. ICF Director will retrain all Residential Team Leaders on developing person-centered plans for clients, to include training objectives to meet their needs. ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records. Target Date: 12/22/2023	

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W 249	Continued From page 6 The finding is: Observations throughout the 11/7/23 - 11/8/23 survey in the group home revealed client #2 to participate in mealtimes and medication administration. Continued observations did not reveal client #2 to be engaged in any other formal training or integrative activities throughout the observation period. Review of the record for client #2 on 11/8/23 revealed a PCP dated 8/1/20. Continued review of the 8/2020 PCP revealed client #2 would like to increase her overall level of independence, enjoys listening to the radio, watching television, looking at magazines, going for a stroll in the neighborhood, and likes to draw while relaxing in a recliner. Subsequent review of the 8/1/20 PCP indicated staff should ask the client a yes/no related questions and/or use pictures of options and have the client choose from the items. Continued review of the 8/2020 PCP indicated the following program objectives: make choices by pointing with her finger, tolerate a manicure, make a collage, toothbrushing goal, use her picture board and point to communicate to staff what activity she wants to participate in as assigned throughout the day. Review of the record did not reveal PCP revisions since 8/1/20. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/8/23 revealed that client #2 should be involved in formal training and integrative activities in the facility throughout the day. Continued interview with the interim QIDP verified that revisions to training and services objectives since 8/1/20	W 249	This page is intentionally left blank	

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W 249	Continued From page 7 could not be located during the survey. Further interview with the interim QIDP verified that client #2 should have updated and revised training objectives as required.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure data was retrieved to determine the accomplishment of the objectives specified in the person centered plan (PCP) was adequately documented in measurable terms for 2 of 3 sampled clients (#2 and #4). The findings are: A. The facility failed to ensure that data relative to the PCP was documented for client #2. For example: Review of the record for client #2 on 11/8/23 revealed a PCP dated 8/1/20 with six program and service objectives. Continued review of the record for client #2 did not reveal a PCP with program objectives for 2021, 2022 and 2023. Subsequent review of the record for client #2 did not reveal PCP program updates, program data, team meeting notes, or QIDP notes to review and determine the client's accomplishments of training objectives towards the 2020 PCP program goals. Review of the record also did not	W 252	A. Program documentation for all individuals will include data relative to the accomplishment of the criteria specified in client individual program plan and objectives will be documented in measurable terms. B. Program data for all individuals will be collected and documented for program objectives and behavior strategies. ICF Director will retrain all Residential Team Leaders that all clients should receive continuous QIDP data reviews to determine progress towards training and behavior objectives. ICF Director will retrain direct support staff on completing measurable documentation of services. ICF Director will follow Monarch's Peer Review schedule to monitor client	

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Target Date: 12/22/2023

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W 252	Continued From page 8 reveal evidence of treatment team meetings, QIDP quarterly reviews or team signatures to approve, update, and implement program goals for 2021, 2022 and 2023. The facility also failed to assure treatment objectives were documented in measurable terms for 2020, 2021, 2022 and 2023 as part of a continuous active treatment program. Interview with the interim qualified intellectual disabilities professional (QIDP) revealed that the program goals and objectives for client #2 could not be found during the 11/7/23-11/8/23 survey for the following years: 2021, 2022, and 2023. Continued interview with the interim QIDP revealed the previous QIDP was relieved of her role on 10/23/23. Further interview with the interim QIDP revealed that all clients should have training objectives and documented updates on program data at least annually. B. The facility failed to ensure program data was collected and documented for program objectives and behavior strategies for client #4. For example: Review of the record for client #4 revealed a PCP dated 1/3/23. Continued review of the record revealed a behavior support plan dated 10/17/22 which indicated the following target behaviors: severe disruption, invading privacy, physical aggression. Further review of the record for client #4 did not reveal behavior data to further determine the accomplishment of behavior objectives since 10/17/22. Subsequent review of the record for client #4 revealed a hospital discharge summary dated 9/2/23, which revealed that the client was	W 252	This page is intentionally left blank.	

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W 252	Continued From page 9 evaluated and treated in the emergency room due to a head injury relative to head banging. Review of the record for client #4 did not reveal self-injurious behaviors (SIBs) or head banging as a target behavior. Interview with the interim QIDP on 11/8/23 revealed that behavior data and QIDP notes could not be located during the survey. Continued interview with the interim QIDP revealed that the previous QIDP was relieved of her role on 10/23/23. Further interview with the interim QIDP revealed that clients should receive continuous QIDP reviews to determine progress towards training and behavior objectives.	W 252		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interviews, the team failed to ensure that data for 2 of 3 sampled clients (#2 and #4) were collected and documented as prescribed for program objectives listed in the person-centered plan (PCP) to determine client progression. The finding is: The team failed to ensure data relative to skill acquisition objectives were reviewed and assessed for clients #2 and #4 as prescribed. For example: Review of the record for client #2 on 11/8/23	W 257	All individual program plans will be reviewed by the QP and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. ICF Director will retrain all Residential Team Leaders on reviewing and revising person centered plans as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records. Target Date: 12/22/2023	

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W 257	Continued From page 10 revealed a PCP dated 8/1/20 which indicated the following program goals: use a communication board and point to communicate to choose activities; toothbrush goal; handwashing goal; make a collage and agree to activity by shaking her head; and tolerate a manicure. Continued review of the 8/1/20 PCP did not reveal team review or assessments of program objectives listed in the plan to determine client progression. Further review of the record for client #2 did not reveal program or service objectives for client #2 for the following years: 2021, 2022, and 2023. Additional review of the record for client #2 did not reveal QIDP assessments or team review since 8/1/20. Review of the record for client #4 on 11/8/23 revealed a PCP dated 1/3/23 which indicated the following program goals: medication administration goal, oral hygiene goal, mop the common area after meals, laundry goal, exercise goal and building blocks activity. Review of the record revealed a behavior support plan (BSP) dated 10/17/22 which indicated the following target behaviors for client #4: invading privacy; yelling/screaming at staff and peers; physical aggression; and use helmet as a protective device. Continued review of the PCP and BSP for client #4 did not reveal QIDP assessments or behavior data of training objectives listed in the plan to determine client progression. Review of the 1/3/23 PCP did not reveal team review or signatures for client #4. Review of the 1/3/23 PCP also did not reveal guardian signature of the PCP until 10/18/23. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/8/23 revealed that the program data and revisions for	W 257	This page is intentionally left blank.	

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W 257	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.	W 257		
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 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 #2's record revealed a PCP dated 8/1/20. Continued review of the record for client #2 did not reveal qualified	W 260	Client #2s PCP will be reviewed and revised at least annually and documented within the clients record as QIDP notes, or interdisciplinary team notes relative to PCP meetings or revisions. ICF Director will retrain all Residential Team Leaders that at least annually, all Person-Centered Plans will be reviewed and revised by the interdisciplinary team and documented by the QP.	

			ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records. Target completion date: 12/22/2023	

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W 260	Continued From page 12 intellectual disabilities professional (QIDP) notes, or interdisciplinary team notes relative to PCP meetings or revisions. Review of the record for client #2 did not reveal PCPs for the 2021, 2022, and 2023 review years. Interview with the interim QIDP on 11/8/23 revealed that the current PCPs for client #2 could not be located during the survey. Continued interview with the interim QIDP revealed the PCP plan team meetings for client #2 had not been completed. Interview with the interim QIDP verified that all clients should have updated PCP reviews at least annually.	W 260		
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 observation, record review and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Observations throughout the recertification survey from 11/7/23-11/8/23 revealed exterior door alarms on exit doors of the facility. Continued observation revealed the door to chime loudly as staff and clients entered and exited the facility. Subsequent review throughout the recertification survey revealed a door alarm on client #5's	W 262	ICF Director will complete, present, and obtain written consent from the HRC committee 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 HRC 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's Peer Review schedule to monitor client electronic medical records.

Target completion date: 12/22/2023

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	34G250	A. BUILDING _____ B. WING _____	C 11/08/2023

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W 262	Continued From page 13 bedroom door. Observation also revealed the bedroom door alarm to chime loudly as the client entered and exited his bedroom. Review of the record for client #5 revealed a person centered plan (PCP) dated 8/22/23. Continued review of the record revealed a behavior support plan (BSP) for client #5 dated 6/9/23. Further review of the 6/9/23 bsp indicated the following target behaviors: AWOL without proper staff supervision; elopement; taking food or beverages not served to him; exposing himself and disrobing; damaging his clothing; jumping on furniture; self-injurious behaviors (SIBs); and flushing items down the toilet. Review of facility documentation on 11/8/23 did not reveal current human rights committee (HRC) limitation consents for clients #1, #2, #3, #4, #5 and #6. Continued review of the facility documentation did not reveal door chimes or alarms to be used as behavior support interventions for the clients. Interview with staff C and E on 11/8/23 revealed the exterior door alarms were to prevent client #5 from AWOL from the property. Continued interview with staff C revealed client #5 also requires close supervision due to AWOL behaviors in addition to the bedroom door alarm. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/8/23 revealed human rights limitation consents for the exterior and bedroom door alarms have not been completed for the clients. Continued interview with the interim QIDP verified that door alarms are used as a behavior support technique for client #5 due to AWOL behaviors. Further	W 262	This page is intentionally left blank.	

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W 262	Continued From page 14 interview with the interim QIDP revealed that although exterior door alarms are required for client #5, HRC limitation consents are required for all clients (#1, #2, #3, #4, #5, and #6) as the restrictive techniques affects all clients.	W 262		
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 observations, record review and interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) relative to exterior door alarms. The finding is: Observations throughout the recertification survey from 11/7/23-11/8/23 revealed exterior door alarms on exit doors of the facility. Continued observation revealed the door to chime loudly as staff and clients entered and exited the facility. Subsequent review throughout the recertification survey revealed a door alarm on client #5's bedroom door. Observation also revealed the bedroom door alarm to chime loudly as the client entered and exited his bedroom. Review of facility documentation on 11/8/23 did not reveal guardian consents for exterior door alarms for clients #1, #2, #3, #4, #5 and #6. Review of the behavior support plan (bsp) dated 6/9/23 for client #5 revealed the bedroom door alarm is to be used as a behavior support intervention for the client. Continued review of	W 263	ICF Director will complete, 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's Peer Review schedule to monitor client electronic medical records. Target completion date: 12/22/2023	

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W 263	Continued From page 15 the record for client #5 did not reveal a guardian consent for the exterior door and bedroom door alarms. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/8/23 revealed guardian consents for the exterior and bedroom door alarms have not been signed and collected for the clients. Continued interview with the interim QIDP verified that door alarms are used as a behavior support technique for client #5 due to AWOL behaviors. Further interview with the interim QIDP revealed that although the door alarms are a behavior intervention for client #5, guardian consent is required for all clients as the interventions affect all clients (#1, #2, #3, #4, #5, and #6). Additional interview with the interim QIDP verified that guardian consents are required annually for the door alarms.	W 263		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on record review and interviews, nursing services failed to ensure the updated dietary assessment was implemented for 1 of 3 sampled clients (#2). The finding is: Review of the record on 11/8/23 for client #2 revealed a nutritional assessment dated 9/29/23. Continued review of the nutritional assessment revealed client #2 has the following prescribed	W 340	ICF Director obtained updated dietary assessment for client #2 on 11/27/2023. ICF Director trained all direct care staff on updated dietary assessment for client #2 on 11/28/2023. ICF Director will train LPN and Residential Manager on ensuring that all dietary assessments are implemented timely or when prescribed. ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records. Target Completion Date: 12/22/2023	

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W 340	Continued From page 16 diet: regular, moist with ground meat except stews and casserole; high calorie prune mixture in the AM; one can soda per day, flax seeds mixed in food; sectional plate and spouted cup with handle. Adding Boost Plus or similar supplement PO twice daily. Further review of the nutritional assessment indicated that the client's weight has been down in the last quarter and the client's BMI indicates that she is underweight. The client is unable to gain weight despite getting Boost Plus supplements twice daily. Review of the 11/2023 medication administration record (MAR) and 10/24/23 physician's order did not reveal that client #2 would receive high calorie prune mixture in the AM. Review of nurses' notes from 8/2023-11/2023 did not reveal information relative to the diet changes for the client. Interview with the facility nurse on 11/8/23 revealed she was not aware of the diet changes for client #2. Continued interview with nursing revealed the agency protocol is for facility management to discuss the changes with the nurse, the nurse will schedule an appointment with the primary care physician to ensure that the diet changes are added to the physician's order, and the staff will be trained on client #2's prescribed diet changes. Interview with the interim qualified intellectual disabilities professional (QI(DP) on 11/8/23 revealed it is facility management's responsibility to inform nursing and staff on prescribed diet changes for clients. Continued interview with the interim QIDP revealed the facility has been through management changes and the facility QIDP is no longer operating in that role. Further interview with the interim QIDP revealed that	W 340	This page is intentionally left blank.	

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W 340	Continued From page 17 nursing, management and staff should follow all diets as prescribed for the clients.	W 340		
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 1 of 3 sampled clients (#2). The findings are: A. The facility failed to ensure that adaptive equipment was repaired and functional for client #2 relative to a wheelchair. For example: Observations throughout the survey from 11/7/23-11/8/23 revealed client #2 to sit in a mechanical wheelchair and to ambulate with staff assistance. Continued observations revealed the wheelchair to have a piece of exposed padding and wood that obtruded into client #2's right side. Further observation on 11/8/23 at 8:00 AM revealed this surveyor to alert staff that the exposed piece of wood was missing a covering and was piercing into the client's right side. Observations also revealed the staff to take a towel and cover the exposed piece of wood. Review of the record for client #2 revealed a PCP dated 8/1/20. Continued review of the record for client #2 revealed an incomplete adaptive equipment monthly checklist. Further review of	W 436	A. The facility will ensure that the adaptive equipment for client #2 is in good repair and functional. OT and National Seat Mobility came out to assess the wheelchair to review the option of replacing or repairing the equipment. B. ICF Director obtained updated OT assessment for client #2 and trained all staff on updated assessment to reflect the implementation of Dycem mat on 11/28/2023. ICF Director will retrain all Residential Team Leaders and direct care staff at Ridgefield Group Home on documentation of adaptive equipment checklist. ICF Director will follow Monarch's Peer Review schedule to monitor client electronic medical records. Target completion date: 12/22/2023	

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W 436	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 independently as her plate slid across the table. At no point during the observation did staff place a dycem mat under the plate to prevent the plate from sliding.	W 436	This page is intentionally left blank.	

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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 table and participate in the breakfast meal. Continued observations revealed client #2's plate to slide as she ate independently. Further observation at 7:20 AM revealed staff to place a towel under client #2's plate to prevent it from sliding. At no point during the observation did staff place a dycem mat under the plate to prevent it from sliding forward. Review of the record for client #2 on 11/8/23 revealed a PCP dated 8/1/20 which indicated that client #2 would like to increase her overall level of independence. Continued review of the 8/2020 PCP revealed that client #2 should use the following adaptive equipment during mealtimes: sectional plate; spouted cup with handles, dycem mat, modified utensils and clothes protector. Review of the nutritional assessment dated 9/29/23 revealed client #2 is able to feed herself independently. Continued review of the record for client #2 revealed an occupational therapy (OT) assessment dated 5/22/23 which listed the following adaptive equipment: hospital bed, bedrails, wheelchair and mechanical lift. Review of the 5/22/23 OT assessment did not reveal adaptive equipment client #2 should use during mealtimes. Interview with staff C on 11/8/23 revealed that client #2 eats well independently. Continued interview with staff C revealed client #2 has not had a dycem mat to improve her level of independence during mealtimes. Interview with the interim QIDP on 11/8/23 revealed that he is not aware if client #2 has previously used a dycem mat during mealtimes. Continued interview with the interim QIDP revealed that he	W 436	This page is intentionally left blank.	

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W 436	Continued From page 20 was unsure why client #2's 5/22/23 OT assessment did not include adaptive equipment the client uses during mealtimes. Further interview with the interim QIDP revealed that client #2 could benefit from using a dycem mat to assist with improving her level of independence during mealtimes.	W 436	This page is intentionally left blank.	