DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER RIDGEFIELD HOME SUMMARY STATEMENT OF DEFICIENCIES (CAN) THE APPROPRIATE (CAN) T	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER RIDGEFIELD HOME STREET ADDRESS, CITY, STATE, ZIP CODE 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) W 000 INITIAL COMMENTS W 000 This facility is in compliance with the CONDITIONS OF PARTICIPATION for Intermediate Care Facilities for Individuals with Intellectual Disabilities found at 42 CFR 483.480 STREET ADDRESS, CITY, STATE, ZIP CODE 730 FISHER RIDGE DRIVE MONROE, NC 28110 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 000 This facility is in compliance with the CONDITIONS OF PARTICIPATION for Intermediate Care Facilities for Individuals with Intellectual Disabilities found at 42 CFR 483.480			34G250	B. WING			10/16/2024		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 000 INITIAL COMMENTS W 000 This facility is in compliance with the CONDITIONS OF PARTICIPATION for Intermediate Care Facilities for Individuals with Intellectual Disabilities found at 42 CFR 483.400 THROUGH 483.460 AND 42 CFR 483.480 W 000 PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OMPLÉTION DATE W 000 W 000 THE APPROPRIATE COMPLÉTION DATE					730 FISHER RIDGE DRIVE	REET ADDRESS, CITY, STATE, ZIP CODE OFISHER RIDGE DRIVE			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		This facility is in conconditions of Intermediate Care Intellectual Disability THROUGH 483.46 (General/Health Research	ompliance with the PARTICIPATION for Facilities for Individuals with ties found at 42 CFR 483.400 0 AND 42 CFR 483.480 equirements).					(AVC) 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.