STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G312	A. BUILDING _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENDALE DRIVE GROUP HOME	1123 RAVENDALE DRIVE CHARLOTTE, NC 28216

(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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 2 clients (#1, #6) were provided the opportunity for privacy. The findings are: A. Observations in the group on 11/13/24 at 6:10 AM revealed client #1 to enter his bedroom. Continued observations revealed client #1 to begin undressing with the bedroom door open which could be seen from the hallway. Further observation revealed client #1 to change his clothing with the door remaining open while staff F stood in the doorway as other clients walked down the hallway to their rooms or use the bathroom. At no time during observations did staff prompt client #1 to close the door or close it for him. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/24 revealed staff have been trained to prompt client #1 with keeping doors closed to ensure privacy. Continued interview with the QIDP revealed staff should have prompt him to shut the door or shut if for him. B. Observations in the group on 11/13/24 at 6:00 AM revealed client #6 to exit the bathroom following his shower and enter his bedroom. Continued observations revealed client #6 to begin dressing with the bedroom door open which could be seen from the hallway. Further observation revealed client #6 to change his clothing with the door remaining open as other	W 129		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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W 129	Continued From page 1 clients walked down the hallway to their rooms or use the bathroom. At no time during observations did staff prompt client #6 to close the door or close it for him. Interview with the QIDP on 11/13/24 revealed staff have been trained to prompt client #6 with keeping all doors closed while getting dressed. Continued interview with the QIDP revealed staff should monitor all clients to ensure privacy and prompt them to shut the door or shut if for them when needed.	W 129		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in hygiene methods specific to ensuring paper supplies were accessible in bathrooms for 6 of 6 clients. The finding is: Observations in the group home on 11/12/24 - 11/13/24 revealed two bathrooms utilized by clients #1, #2, #3, #4, #5 and #6. Continued observations of both bathrooms revealed no paper towel or hand soap in the dispensers in either bathroom throughout observations. Further observations revealed clients #2, #3, #4, #5 and #6 at various times to enter into the bathrooms, wash their hands with no paper towel or soap products, close the door and to exit the bathroom. Subsequent observations revealed both bathrooms to remain with no paper towels or	W 189		

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W 189	Continued From page 2 soap products throughout the observation period. Interview with the Home Manager (HM) on 11/13/24 verified that there were no paper towels or soap products in both bathrooms and that the soap dispenser was not working but maintenance personnel was aware of it. Continued interview with the HM confirmed that all bathrooms should have an ample supply of paper products and soap. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/24 verified all bathrooms should have an ample supply of paper products and soap available to clients when occupying the bathrooms in the group home.	W 189		
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 observations, record reviews and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for clients (#4 and #5). The finding is: Observations throughout the recertification survey period from 11/12/24 - 11/13/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Continued observations revealed video cameras installed throughout the group home. Review of record for client #4 on 11/13/24 did not	W 262		

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W 262	Continued From page 3 reveal signed consents by the HRC for exit door alarms. Review of record for client #5 on 11/13/23 did not reveal signed consents by the HRC relative to the exit door alarms or video cameras installed throughout the group home. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/24 revealed that signed consent forms for clients #4 and #5 could not be located during the survey. Continued interview with the QIDP revealed HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	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 reviews and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 6 clients (#4, and #5). The finding is: Observations throughout the recertification survey period from 11/12/24 - 11/13/24 revealed exterior doors alarm to chime as staff, clients and surveyors entered and exited the group home. Continued observations revealed video recording cameras installed throughout the group home. Review of record for client #4 on 11/13/24 revealed no signed consents from the legal	W 263		

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W 263	Continued From page 4 guardian for the exit door alarms. Review of record for client #5 on 11/13/24 revealed no signed consents from the guardian relative to door alarms or video cameras installed throughout the group home. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/24 revealed that the signed consent forms for clients #4 and #5 could not be located during the survey. Continued interview with the QIDP revealed HRC limitation consent forms for all clients should be updated and signed by the legal guardian annually.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure techniques to manage client #1 and #3's behavior was included in a formal active treatment program. The finding is: Observations in the group home throughout the 11/12/24 - 11/13/24 survey revealed clients and staff to access personal hygiene bins from a locked closet in the dining room area. Continued observations revealed staff and clients to return to the closet, staff to unlock the closet and place hygiene bins in their respective places. Further observations when asked by surveyors to look into the bins revealed one tube of toothpaste in a bin.	W 288		

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W 288	Continued From page 5 Interview on 11/12/24 with the Home Manager (HM) revealed all six clients hygiene bins are kept locked in the closet and is accessible to the clients when its time to complete personal hygiene. Continued interview with the HM revealed toothpaste are not provided in all clients bins because clients #1 and #3 has a tendency to misuse and swallow the toothpaste if not supervised. Further interview with the HM revealed staff is to place a small amount into a medication cup and give to the client when it's time to brush their teeth. Subsequent interview with the HM revealed because of client #1 and #3's misuse and swallowing toothpaste incidents, client's #2, #4, #5 and #6 hygiene bins are also kept locked in the closet. Review of record for client #1 on 11/13/24 revealed a behavior support plan (BSP) dated 8/14/24. Continued review of the BSP revealed the following targeted behaviors: noncompliance/agitation, PICA, taking others food, intentional toileting accidents, SIB, elopement or elopement attempts, other behaviors of concern, staying up at night and/or disturbed sleep, may want to get food seen earlier and will attempt to obtain it during the night. Further review of the BSP did not reveal the need to keep the client's hygiene bin in a locked closet. Review of record for client # 3 on 11/13/24 revealed a BSP dated 8/14/24. Continued review of the BSP revealed the following target behaviors: agitation and physical aggression. Further review of the BSP did not reveal the need to keep the client's hygiene bin in a locked closet.	W 288		

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W 288	Continued From page 6 Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/24 confirmed client's #1 and #3 BSP's are current. Continued interview with the QIDP revealed there is no documentation available to justify the need to lock all six clients hygiene bins in a closet.	W 288		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation and interview, the system for drug administration failed to assure 1 non sampled client (#3) observed during medication administration were provided education related to name, purpose and side effects of medications administered. The finding is: During a medication administration observation on 11/13/24 at 6:15 AM revealed staff G to call client #3 to the medication room. Continued observations revealed staff G to verify the medication blister pack to the medication on the MAR. Further observations revealed client #3 to participate in punching the following medications Amlopidine 10 mg, Chlorpromazine 10mg, Famotidine 20mg, Fluvoxamine 25mg, Furosemide 20mg, Levocarntine 330mg, Losartan 100mg, Oyst Shell D3 500mg, Phenytoin 50mg, Phenytoin Extended 100mg, and Vitamin D 1000 units out the blister pack into the medication cup.	W 371		

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W 371	Continued From page 7 Further observations revealed staff G to pour a Benefiber packet into a medication cup mix with water. Subsequent observations revealed staff G to hand client #3 the medication cup, he took all medications with a cup of water mixed with Benefiber and the client exited the med room. Additional observations did not reveal client #3 to receive any education related to name, purpose and side effects of medications administered. Interview with the newly hired facility nurse on 11/13/24 verified that client #3 had some level of independence to participate with the training and education during the medication administration. Continued interview with the facility nurse revealed although she's not fully trained with the agency process with medication administration, clients should be provided some sort of education relative to the medications prescribed.	W 371		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental levels and prescribed diets of 2 of 6 clients (#1 and #2). The findings are: Observations in the group home on 11/12/24 from 4:00 PM - 6:00 PM revealed all clients to sit at the table to participate in the dinner meal. Continued observations at 5:25 PM revealed clients #1 and #2 to fix their dinner plates which consist of chopped oven fried fish, baked sweet potato, mechanical soft green beans, pudding, water,	W 474		

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W 474	Continued From page 8	W 474		

and juice following verbal and hand over hand assistance from staff. Further observations revealed clients #1 and #2 to consume their meals as served.

Review of the facility menu on 11/12/24 revealed the following for dinner; 3/4 oven fried fish, 2 tablespoon tarter sauce, 1/2 small baked sweet potato 1/2 cup green beans, 10-15 grapes, 1 tablespoon low fat margarine, banana pudding, 1 cup 1% milk, SF beverage and water.

Observations in the group home on 11/13/24 from 6:00 AM - 8:00 AM revealed at 7:15 AM all clients to sit at the table to participate in the breakfast meal. Continued observations at 7:18 AM revealed staff to fix a bowl of raisin bran cereal and a small muffin broken into 1/4 pieces for client #1. Further observations revealed client #2 to fix a bowl of cheerios cereal, client #4 to pour milk into client #2's bowl and staff to place a small muffin on a napkin, pour juice and water into client #2's cup. Further observations revealed clients #1 and #2 to consume their meals as served.

Review of the facility menu on 11/13/24 revealed the following for breakfast; 1 cup whole grain cereal, 1 cheese muffin, 1 tablespoon margarine, 1/2 banana, 1 cup 1% milk, decaf coffee and water.

Review of record for client #1 on 11/13/24 revealed a nutritional assessment (NA) dated 7/31/24. Continued review of the NA revealed client #1's diet listed as 1800 calorie, low cholesterol and mechanical soft.

Review of record for client #2 on 11/13/24

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W 474	Continued From page 9 revealed a NA dated 2/29/24. Continued review of the NA revealed client #2's diet listed as mechanical soft. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/24 revealed clients #1 and #2 NA's are current. Continued interview verified clients #1 and #2 diets were not served as prescribed. Further interview with the QIDP revealed the clients diets are listed in the homes and staff should have followed them as prescribed.	W 474		