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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G003	A. BUILDING _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J. IVERSON RIDDLE DEVELOPMENTAL CENTER	300 ENOLA ROAD MORGANTON, NC 28655

(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 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, record review and interview, the facility failed to ensure 1 of 1 client (#17) received a continuous active treatment program consisting of needed interventions and services as identified in the Behavioral Support Plan (BSP) in the area of adaptive implementation. The finding is: During observations throughout the survey on 11/19/24 - 11/20/24 revealed client #17 to participate in group activities, mealtime, and medication administration in the dayroom. Continued observations revealed client #17 to chew on her right hand with all fingers inside her mouth throughout her day. Further observations revealed at no point did staff prompt or encourage client #17 to use her chewable collar or wash cloth. Review on 11/20/24 of client #17's behavioral support plan (BSP) dated 8/21/24 revealed client #17 to have a target behavior to include mouthing. Continued review revealed staff is to provide client #17 with a washcloth or chewable collar attached to a vest for sensory	W 249	**W249** By December 20, 2024, an Occupational Therapy and psychology referral will be completed for Client #16, to evaluate the most appropriate, safe and preferred items for the resident to be redirected to when mouthing and redirection techniques to be employed by staff. Responsible Persons: Lakeside Area Director/Director of OT & PT/Director of Psychology By December 27, 2024, Client #16's BSP will be updated, as needed, to incorporate any changes resulting from psychology referral, if applicable. Responsible Persons: Director of Psychology By December 27, 2024, a mini-team meeting will be held for client #16 to review the recommendations from the previously mentioned referrals to incorporate recommendations and changes into the clients PCP. Responsible Persons: Lakeside Area Director By December 31, 2024, staff who work with resident #16 will be in-serviced on PCP and/or BSP changes. Responsible Persons: Lakeside Area Director/ Director of Psychology	

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

Treat. Director 11/12/24

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 249	Continued From page 1 reinforcement need and to help her from putting her hands in her mouth. Subsequent review revealed client #17 will be provided appropriate items to chew or mouth on throughout her day approved by the Interdisciplinary Team (IDT). Interview on 11/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #17 chews on her right hand throughout the day and that staff should have provided client #17 with a washcloth. Continued interview with the QIDP revealed client #17's chewable collar was not attached to her vest and that client #17 prefers the washcloth.	W 249		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to provide clients with nursing services in accordance with their needs. The findings are: A. The facility failed to provide medication education to client #9 at Hemlock. For example: Observations on 11/20/24 at 8:43 AM revealed client #9 to enter the medication room for medication administration. Continued observations revealed the nurse to prepare all medications and serve to client in chocolate pudding. Further observations revealed the nurse to administer two topical ointments to the client's head and face. At no time did the nurse provide education regarding the client's medications. Interview with the nurse supervisor on 11/20/24	W 331	**W331** By December 20, 2024, *Nursing Policy 6.2 Medication-Policies*, and *Nursing Policy 6.3 Medication Administration Procedure* will be updated to reflect language r/t resident education during medication administration. By January 10, 2025, all campus nurses will be trained, and training rosters will be provided on the new policy updates. The medication administration observation that each nurse supervisor does on each nurse quarterly will include language to ensure that resident education occurs with each medication administration. Responsible Persons: Director of Nursing	

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W 331	Continued From page 2 confirmed all clients should be provided with education on their medications. B. The facility failed to provide education to client #8 at Poplar during medication administration. For example: Observations on 11/19/24 at 5:20 PM revealed client #8 to enter the medication room, the nurse to hand him a cup with medications from out of the medication cart. Continued observations revealed the client to consume the medications followed by water. Further observations revealed client #8 to exit the medication room. At no time during observations did the nurse provide education relative to the client's medications. Interview with nursing services on 11/20/24 revealed the nurse should have provided education to the client during medication administration. C. The facility failed to provide nursing services to client (#15) as deemed necessary on the Maple Unit. For example: Observations throughout the recertification survey from 11/19/24-11/20/24 revealed client #15 to have a dime-sized sore on the left cheek. Continued observations revealed the sore to be healing but still red in color. Review of the record for client #15 on 11/20/24 revealed an IPP dated 3/26/24. Continued review of the record for client #15 revealed a behavior support plan (BSP) dated 1/2024 which indicated the following target behaviors: g-tube removals, self-injurious behaviors, and g-tube pulls. Review	W 331		

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W 331	Continued From page 3 of the record did not reveal nursing notes, doctor's notes or documentation relative to the scratch on client #15's left cheek. Review of the record for client #15 did not reveal skin picking as a target behavior. Subsequent review of the record for client #15 did not reveal an incident report or documentation in the nurses' communication log relative to the client picking her skin and the wound on the left cheek. Interview with nursing services on 11/19/24 revealed client #15 scratches her face often and while the wound is healing the client will continue skin picking. Interview with nursing services on 11/20/24 revealed that nursing has contacted the doctor regarding client #15's wound on her cheek and have been instructed to apply an ointment to the wound. Continued interview with nursing services revealed that a nurses' notes should have been completed when the wound is being monitored and treated. Further interview with nursing services revealed that client #15 often picks her skin and the behavior should be tracked in the client's BSP. Interview with the qualified intellectual disabilities professional (QIDP) on 11/20/24 verified that client #15 picks at the wound on a regular basis. Continued interview with the QIDP revealed that behavior data is not being tracked for skin picking for client #15, however nurses' notes should be written and placed in the client's chart when treatment is provided and the client injures herself. D. The facility failed to provide medication education to clients (#20, #21, #22) during medication administration on the Maple Unit. For example:	W 331	**W331** By December 13, 2024, a late entry will be made in client #15's chart with a short-term nursing care plan r/t the cheek wound and follow up notes will be made until resolution of problem. By January 10, 2025, the RN in the home will assess client #15 to determine if any additions need to be made to the annual Nursing Care Plan r/t client picking at wounds. By January 10, 2025, the Maple nurses will be in-serviced on *Nursing Policy 1.4 Accidents/Incidents (Reporting Procedures)* and *Nursing Policy 4.1 Nursing Assessment Policy*. Copies of training rosters provided. Going forward, documentation of injuries will occur at least monthly by the Nursing Supervisor and tracked on the employee performance tracker, as well as during utilization review of each patients chart every 6 months. Responsible Persons: Director of Nursing	

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W 331	Continued From page 4 Observations on 11/20/24 from 7:25AM-8:00AM revealed three clients (#20, #21, #22) to enter the medication room at various times to participate in medication administration. Continued observations revealed nursing to provide medications to all three clients (#20, #21, #22) by offering pudding, water, or juice for administration. Further observations revealed nursing to provide medications to the three clients in a cup without providing medication education such as the medication type and usage. Interview with nursing services on 11/20/24 revealed clients that participate in medication administration take a more active role in receiving their medications. Continued interview with nursing services verified that nursing should provide medication education to clients to include the type of medication and usage.	W 331	**W331** By December 20, 2024, *Nursing Policy 6.2 Medication-Policies*, and *Nursing Policy 6.3 Medication Administration Procedure* will be updated to reflect language r/t resident education during medication administration. By January 10, 2025, all campus nurses will be trained, and training rosters will be provided on the new policy updates. The medication administration observation that each nurse supervisor does on each nurse quarterly will include language to ensure that resident education occurs with each medication administration. Responsible Persons: Director of Nursing	
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all drugs were administered in compliance with the physician's orders. The findings are: The facility failed to document medication administration for client #19 at Elm. For example: Observations on 11/20/24 at 7:15 AM revealed client #19 to enter the medication room for medication administration. Continued	W 368		

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W 368	Continued From page 5 observations revealed the client to receive the following medications: Vitamin D3, Sennosides 8.6mg, Omeprazole 20mg, and Depakote 500mg. Review of client #19's record on 11/20/24 revealed physician's orders dated 8/27/24 which indicated the client receives the following medications daily at 8:00 AM: Vitamin D3, Sennosides 8.6mg, Omeprazole 20mg, Depakote 500mg, and Sodium Fluoride 1.1% toothpaste. Review of client #19's medication administration record (MAR) for November 2024 revealed missing documentation for the administration of the Sodium Floride 1.1% toothpaste for 11/3, 11/7, 11/12, 11/16, 11/18, and 11/20. Interview with direct support staff on 11/20/24 revealed they administered the Sodium Fluoride 1.1% toothpaste at 8:15 AM, but forgot to document it in the MAR. Interview with the nurse supervisor confirmed the Sodium Fluoride 1.1% toothpaste should be administered and documented daily as prescribed.	W 368	**W368** By January 10, 2025, all appropriate staff will be in-serviced in Nursing Policy 6.20 Treatment Administration by Non-Nursing Staff. Copies of training rosters provided. Nurses in each home will check HTAR records daily on 1st and 2nd shifts, initialing to ensure that treatments were provided and HTAR was signed. Procedure for correction outlined in the policy will be performed if treatment not completed or signed. Nurses in each home will initial on the MAR weekly that they have assessed the resident's response to the listed treatment. Nurse supervisors will monitor the HTAR and MAR records at least quarterly during medication administration observations on each nurse. Responsible Persons: Director of Nursing	
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all drugs were administered without error for 1 of 2 clients (#17) observed during medication administration. The finding is: Observation on 11/20/24 at 7:21am revealed nurse and client #17 to sanitize hands and	W 369		

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W 369	Continued From page 6 prepare for medication administration in client #17's bedroom. Continued observation revealed nurse to remove client #17's medication basket from locked cart and dispense each pill into a small cup. Further observations revealed nurse to dispense first pill into the cup whole, then she removed the pill from the cup to crush after she crushed the second pill. Subsequent observation revealed nurse to crush two additional medications, opened one capsule pill, and pour liquid medications into a cup with Miralax and apple juice . Observations also revealed nurse to administer the morning medications to client #17 by mouth. Review of records for client #17 on 11/14/24 revealed physician orders dated 10/8/24 and Medication Administration Record (MARS) dated November 2024 did not state medications were to be crushed or opened during administration. Interview with the facility nurse on 11/14/24 confirmed the 10/8/24 physician orders for client #17 to be current. Continued interview with the facility nurse revealed that she thought it was noted on the physician orders and will notify the physician for clarification.	W 369	**W369** By January 10, 2025, Client #17's POU will be updated to reflect that medications are to be crushed. *Nursing Policy 6.2 Medication-Policies* will be updated. All nurses will be in-serviced on the updated policy. Training rosters will be provided. Nurses will be trained according to the updated policy to enter information about crushing medication in the notes section of the MC+ app for those residents affected. That will be printed on the POU every 90 days which will be reviewed by the RN, noted, and signed by the attending physician. The annual Medication Self-Administration Assessment will also reflect this information and is kept on the MAR for each resident. This will then be reviewed every 90 days on the POU, and annually on the Medication Self-Administration Assessment. Responsible Persons: Director of Nursing	
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to keep all drugs and biologicals locked except when being prepared for administration. The findings are:	W 382		

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W 382	Continued From page 7 A. The facility failed to ensure medications were kept locked at Elm. For example: Observations on 11/20/24 at 7:10 AM revealed the nurse to administer a client their medications. Continued observations at 7:12 AM revealed the nurse to exit the medication room to retrieve another client for medication administration. Further observations revealed the medication room door to be left open and the medical cart unattended with mutiple drawers open. Interview with the nurse on 11/20/24 revealed the medication cart will automatically lock after five minutes and they are supposed to lock the cart when they exit the medication room. Interview with the nurse supervisor on 11/20/24 confirmed nursing staff are responsible for ensuring all prescription medications are kept locked except when being prepared for administration. B. The facility failed to assure all medications and biologicals remained locked except when being prepared for administration in the Maple Unit. For example: Observations on 11/20/24 from 7:00AM-12:00PM revealed three bathrooms to have cabinets with locks and toiletry caddies for the clients' personal toiletries and supplies. Continued observations revealed several cabinets to be unlocked with the following topical medications inside of them: Hibiclens, Clindamycin, and Nystatin. Interview with nursing services on 11/20/24 revealed that the cabinets were unsecured as the staff were applying the topical medications after their showers and during personal care.	W 382	**W382** By January 10, 2025, all nurses will be in-serviced on *Nursing Policy 6.2 Medication-Policies*. Training rosters provided. Nurses will check that medication carts are locked prior to leaving them unattended. Nursing supervisors will randomly check that carts are locked during routine rounding, and during quarterly medication administration observation of each nurse. By December 20, 2024, *Nursing Policy 6.20 Treatment Administration by Non-Nursing Staff* will be updated to include the home nurse ensuring HTAR's are locked at the time they sign off on administration. By January 10, 2025, all appropriate staff will be in-serviced on *Nursing Policy 6.20 Treatment Administration by Non-Nursing Staff*. Training rosters provided. Responsible Persons: Director of Nursing	

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W 382	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This affected clients (#12, #17, and #18). The findings are: A. During afternoon observations in the facility throughout the survey on 11/19-20/24 at various times from 4:00pm -5:15pm and 8:00am-8:30am. Client #18 was observed licking a picture hanging on the wall in the activity room, picking up a shoe string from the floor licking it then giving it to another client and licking a pillow that was laying on the counter in the kitchen. Interview on 11/20/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #18 doesn't exhibit that licking behavior often . There is no protocol in place to clean items.	W 382		
W 454		W 454	**W454** By December 27, 2024, a sanitation protocol will be developed and trained to all staff serving Client #18. This training will be documented on in-service rosters. Responsible Persons: Summit Area Director/Redwood Resource Center Director By December 20, 2024, a psychology referral will be completed for client #18 to determine the need for data collection and/or behavioral guidelines for licking behavior. Responsible Persons: Summit Area Director/Director of Psychology By December 27, 2024, a miniteam will be held to incorporate changes into the PCP. Responsible Persons: Summit Area Director By December 31, 2024, any plan changes resulting from the psychology referral will be in serviced to staff serving client #18. This training will be documented on a training roster. Responsible Persons: Director of Psychology	

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W 454	Continued From page 9 B. Observations on 11/20/24 at Poplar at 7:53 AM revealed client #12 to pour syrup into a small bottle, pick up the trash can cover, then place the trash can cover on top of the kitchen counter top. Continued observations revealed client #12 to place and screw the lid on the syrup bottle with the same hand he opened the trash can, remove the lid, then placed it on the kitchen countertop. Further observations revealed client #12 to particiapte in breakfast meal. At no time did staff prompt client #11 to wash his hands after opening the trash bin or remove the trash can cover from the kitchen counter top. Subsequent observations at 11:45 AM revealed the trash can lid to sit on the kitchen countertop next to the silver containers with lunch items inside. Additional observations as surveyor left at 11:48 AM revealed that the lid remained on the kitchen countertop. Interview with the assigned spotter on 11/20/24 revealed staff should prompt client #12 to wash his hands and redirect client to not place the trash can lid on the kitchen countertop. C. Observations on South Cedar (Oak) throughout the survey on 11/19-20/24 at various times revealed client #17 to participate in group activities in the day room and classroom with other clients. Continued observations revealed client #17 to chew on her right hand(all fingers inside her mouth) throughout her day. Further observations revealed client #17 to use her right hand when prompted by staff to hold activity items and then she put her right hand back inside her mouth. Subsequent observations revealed staff to pass the same activity items to the other clients in the group. At no point did staff sanitized	W 454	**W454** By January 1, 2025, a skills acquisition program will be formulated for Client #12 to place the trash can lid on the floor when emptying the trash. The program will incorporate hand washing after touching the trash can. This will complement and reinforce the program Client #12 is currently on to wash his hands before putting away clean laundry. Responsible Persons: Lakeside Area Director By January 10, 2025, staff who work with Client #12 will be in-serviced on data collection and running the program to teach Client #12 to place the trash can lid on the floor and wash hands after handling the trash can. This training will be documented on in-service rosters. Responsible Persons: Lakeside Area Director By January 15, 2025, all JIRDC direct care staff will be in-serviced on providing hand washing prompts/assistance to residents after they come in contact with any bodily fluids or potentially contaminated surfaces. This training will be documented on in-service rosters. Responsible Persons: Area Directors/Resource Center Directors	

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W 454	Continued From page 10 the items nor provide client #17 with hand sanitizer. Interview on 11/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #17 chews on her right hand throughout the day and that staff should have provided client #17 with a washcloth.	W 454	**W454** By December 20, 2024, weekly monitoring of shared leisure item cleaning procedures in the area for be implemented x 4 weeks. Responsible Persons: CWE Area Director By December 13, 2024, Weekly monitoring of shared leisure item cleaning procedures in the Rosewood Resource Center will be implemented x 4 weeks. Responsible Persons: Rosewood Resource Center Director	
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure clients receive a nourishing, well-balanced diet including modified and specially prescribed diets. The findings are: A. The facility failed to provide a specially prescribed diet to client #9 at Hemlock. For example: Observations on 11/19/24 revealed client #9 to be served two 8-ounce cartons of chocolate milk at both the lunch and dinner meal. Continued observations revealed the client to be served a third 8-ounce carton of regular milk during the dinner meal. Further observations on 11/20/24 revealed the client to be served two 8-ounce cartons of chocolate milk with the breakfast meal. Review of the client #9's record on 11/20/24 revealed a nutritional evaluation dated 11/1/24.	W 460	**W460** By December 20, 2024, a dietician referral will be completed to clarify client #9's diet order re: milk. By December 27, 2024, the diet order will be updated, as needed, and a miniteam will be performed to incorporate any changes resulting from the referral into client #9's PCP. By December 31, 2024, all staff working with client #9 will be in serviced on changes. This training will be documented on a training roster. Responsible Persons: Summit Area Director/Director of Nutritional Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G003	A. BUILDING _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J. IVERSON RIDDLE DEVELOPMENTAL CENTER	300 ENOLA ROAD MORGANTON, NC 28655

(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 460	Continued From page 11 Review of the nutritional evaluation indicated client #9's prescribed diet as "regular calorie, all foods cut up, regular liquids, low fat, low cholesterol, high fiber, 1 whole carton of milk or chocolate milk TID with meals. Benefiber 1 packet BID, no hot sauce, service rice with gravy." Continued review of the client's record revealed physician's orders dated 8/27/24 which indicated they recevie "1 cup milk/chocolate milk TID with meals." Interview with the nutritionist on 11/20/24 confirmed client #9's nutritional evaluation is current. Continued interview confirmed staff are responsible for ensuring the client's diet order is followed as prescribed. B. The facility failed to ensure client #11 at Poplar received meals as prescribed. Dinner observations on 11/19/24 at 6:00 PM revealed client #11 to participate in dinner meal which consisted of 3 oz oven fried chicken, 2 oz gravy, 4 oz mashed potatoes, 4 oz broccoli florets, and ice cream. Continued observations revealed client #11 to fix his plate with verbal prompts, consume the dinner meal, put scraps in the trash can, sit back at the table and scoop 2 large servings of potatoes in his plate. Further observations revealed client #11 to consume the mashed potatoes, place scraps in the trash can then circle back into the kitchen area. Breakfast observations on 11/20/24 at 8:00 AM revealed client #11 to participate in breakfast meal which consist of 2 pancakes with syrup, 4 oz grits or cold cereal, 2 turkey sausages, milk and coffee. Continued observations at 8:10 revealed client #11 to remove a plate out of the	W 460	**W460** By December 20, 2024, a dietician referral will be completed for client #11 to determine if there are low calorie foods that can be offered as seconds. By December 27, 2024, the diet order will be updated, as needed, and a miniteam will be performed to incorporate any changes resulting from the referral into client #11's PCP. By December 31, 2024, all staff working with client #11 will be in serviced on his prescribed diet; including how best to provide redirection, if necessary, when he makes choices not consistent with his diet order. This training will be documented on in-service rosters. Responsible Persons: Lakeside Area Director, Director of Nutritional Services/ Director of Psychology	

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

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	34G003	A. BUILDING _____ B. WING _____	11/20/2024

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W 460	Continued From page 12 microwave with 3 sausage patties he had placed in the microwave earlier to cook. Further observations revealed client #11 to sit at the chair in the corner, then staff to prompt him to sit at the dining table where he consumed the sausage patties. Review of record for client #11 on 11/20/24 revealed a nutritional assessment dated 6/7/24. Continued review of the assessment revealed the following diet: regular, no extra servings at meals, NAS (don't use salt shaker), nutrisource fiber, 1 packet or 2 oz fiber juice daily with breakfast, encourage fluids. Further review revealed an overall significant weight gain over the past year. BMI slightly overweight. Extra servings were discontinued on 7/3/23 due to weight gain. Interview with the assigned spotter revealed the client's nutritional assessment is current.	W 460	Beginning the week of January 6, 2025, mealtime monitoring will be conducted weekly by the Home Manager and monthly by the QIDP to ensure Client #11 is being properly redirected when he makes choices outside of his diet order. This monitoring will be documented on Mealtime Observation sheets. Responsible Persons: Lakeside Area Director	
W 476	MEAL SERVICES CFR(s): 483.480(b)(3) Food served to clients individually and uneaten must be discarded. This STANDARD is not met as evidenced by: The facility failed to assure health and safety of 2 clients (#13 and #14) in Poplar by not ensuring food consumed was discarded prior to the expiration date. The finding is: Observations in the group home on 11/20/24 at 7:30 AM revealed the clients to participate in the breakfast meal consisting of pancakes, grits or cereal, turkey sausage and milk. Continued observations revealed client #13 and client #14 to be served milk in drinking cups from an opened gallon container in the refrigerator. Further	W 476	**W476** By December 20, 2024, Staff in Poplar will be in-serviced on ensuring that expired food is not provided to residents and is discarded by the expiration date. This training will be documented on in-service rosters. Responsible Persons: Lakeside Area Director By 12/20/24, Staff on 3rd shift will check the contents of the refrigerator nightly and will dispose of any food that will expire before breakfast. These checks will be documented on Food Safety logs kept on each refrigerator in Poplar and reviewed and initialed by the QIDP weekly x 4 weeks. Responsible Persons: Lakeside Area Director	

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W 476	Continued From page 13 observations revealed that the clients consumed the milk. Additional observations revealed the milk had an expiration date of 11/19/24. Interview on 11/20/24 with the assigned spotter confirmed that expired food should not be provided to the clients and was discarded.	W 476		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK T. BENTON • Deputy Secretary for Health
KAREN BURKES • DSOHF Director
TODD DRUM • JIRDC Director

December 12, 2024

Justin Foster, MPA, QIDP
Facility Compliance Consultant II
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: Plan of Correction for Recertification Survey – November 19-20, 2024
J. Iverson Riddle Developmental Center, 300 Enola Rd., Morganton, NC
Provider Number #34G003
E-mail Address: justin.foster!@dhhs.nc.gov

Dear Mr. Foster:

It was again a pleasure to welcome you to our campus for our annual recertification survey. We appreciate the professional and thorough approach in which you and your team conducted your review.

Attached is an electronic copy of the Plan of Correction (POC); the signed original will be placed in the mail to your attention. I believe the responses should be satisfactory but if you have questions or need additional information, please let me know. I can be reached by phone at 828.608.6010 or by email at Todd.Drum@dhhs.nc.gov.

Please extend our thanks to the entire team, we appreciate everyone's time and feedback.

Sincerely,

Todd Drum, Director
J. Iverson Riddle Developmental Center

Enclosure: POC Pages 1-14