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	34G302	A. BUILDING _____ B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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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E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Review on 1/21/25 of the facility's EP plan (dated 3/14/24) did not indicate all new and/or existing staff had received training and/or retraining on the EP plan. Interview on 1/21/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she could not be sure if staff training on the EP plan had been completed and no documentation could be located.	E 037		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure each client's active treatment program was monitored to determine	W 159		

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the need for program revisions based on the client's performance. This affected 2 of 4 audit clients (#1 and #5). The findings are:

A. Review on 1/21/25 of client #1's Individual Program Plan (IPP) dated 12/13/24 revealed the following objectives implemented 9/20/22:

- follow a laundry routine with 100% verbal prompts or less for 10 consecutive review periods
- purchase an item for $2 or less with 100% verbal prompts or less for 10 consecutive review periods
- participate in a leisure activity for 10 minutes daily (M - F) for 10 consecutive review periods

Additional review of client #1's record did not include a recent review of the programs to determine progress after the client had trained on the objectives for over two years.

Interview on 1/21/25 with the QIDP confirmed client #1 continues to train on the objectives; however, no progress notes had been written to determine the client's preformance on the objectives.

B. Review on 1/21/25 of client #5's IPP dated 11/4/24 revealed the following objectives:

- prepare a side dish for dinner with 100% independence for 10 consecutive review periods (implemented 9/12/22)
- complete oral hygiene with 100% verbal prompts for 10 consecutive review periods (implemented 8/12/22)
- perform an exercise regimen twice daily with 100% correct responses for 10 consecutive review periods (implemented 8/12/22)

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W 159	Continued From page 6 Additional review of client #5's record did not include a current review of the programs to determine progress after the client had trained on the objectives for over two years. Interview on 1/21/25 with the QIDP confirmed client #5 continues to train on the objectives; however, no progress notes had been written to determine the client's performance on the objectives.	W 159		
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 interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program plan (IPP) in the areas of adaptive equipment use, dining and supervision. This affected 3 of 4 audit clients (#1, #4 and #5). The findings are: A. During afternoon observations at the day program on 1/21/25 from 11:50am - 12:50pm, two staff (Staff A and Staff G) provided one-to-one	W 249		

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direct supervision for two clients in the room while Staff C was responsible for supervision of the five remaining clients, three of which were client #1, client #4 and client #5. At 12:03pm, client #1 left the room and went to the bathroom without supervion. At 12:11pm, Staff C left the room to take client #4 to the bathroom. Before leaving the room, she asked Staff G (1 to 1 staff for another client) to watch her remaining clients in the classroom. This left client #1 and client #5 unsupervised in the classroom. Staff C remained out of the room for approximately 20 minutes. During this time, client #1 periodically walked around the classroom manipulating items.

During an interview on 1/21/25, when asked if she was working in the classroom with anyone, Staff C revealed another staff was available across the hall in a classroom if she needed them.

Interview on 1/21/25 with Staff G revealed she was responsible for another client in the room; however, she usually watches other clients if Staff C has to leave the room.

Review on 1/21/25 of client #1's Behavior Support Plan (BSP) dated 5/9/24 revealed an objective to address inappropriate behaviors including property destruction, taking items not belonging to him, aggression and not making responsible choices. The BSP noted, "Staff will continue to monitor [Client #1] in areas where he can gain access to food or beverages...Staff should always be aware of [Client #1's] whereabouts."

Review on 1/21/25 of client #5's IPP dated 11/4/24 indicated, "[Client #5] requires 24-hour supervision for medical and the ablility to identify

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dangerous situations." Additional review of the plan noted client #5 had been admitted to the home due to her need for "high supervision" and "access to supervised community based educational and vocational day programming activities."

Interview on 1/21/25 with Staff F who works at the front desk at the day program revealed the staffing in the ICF classroom had been reduced due to a fewer number of clients in that classroom. Additional interview indicated the number of staff in classroom is determined by management at the day program.

Interview on 1/21/25 with the Quality Assurance (QA) Consultant indicated Staff C should seek assistance from the front desk staff via an intercom system in the room if she requires assistance with clients in the classroom. Additional interview confirmed the two other staff in the classroom are only responsible for their one-to-one assigned clients.

B. During lunch observations in the classroom at 11:50am, Staff C fed client #4 his entire meal from a Tupperware container using a built-up handle spoon. The staff held a Gatorade bottle to the client's mouth as he drank from it. Other than the adaptive spoon, no other adaptive dining equipment was utilized.

Interview on 1/21/25 with Staff C revealed client #4 usually helps feed himself; however, he "looked like" he didn't feel good. The staff also indicated the client has an adaptive cup available for use in the classroom.

Review on 1/21/25 of client #4's IPP dated 5/3/24

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revealed his adaptive eating equipment included an enlarged handle eating utensil, sectioned plate with high sides, weighted cups and dycem mat. Additional review of the plan noted at times he eats with partial physical assistance, drinks from a cup with partial assistance and needs to improve his self-feeding skills.

Interview on 1/21/25 with the Qualified Intellectual Disabilites Professional (QIDP) confirmed client #4 can assist with feeding himself and should use all adaptive dining equipment identified in his IPP.

C. During observations of medication administration in the home on 1/21/25 at 3:23pm, Staff A held a bottle of Ensure to client #4's mouth as he drank from it. The client was not assisted to utilize any adaptive equipment during this time.

Review on 1/21/25 of client #4's IPP dated 5/3/24 revealed he uses weighted cups to assist with drinking.

Interview on 1/21/25 with the QIDP confirmed client #4 uses adaptive cups to assist with drinking.

D. During dinner observations in the home on 1/21/25 at 5:14pm, client #4 was assisted to feed himself with built-up handle spoon, sectioned plate, and a weighted cup with a lid and handle. No other adaptive dining equipment was utilized.

Review on 1/21/25 of client #4's IPP dated 5/3/24 revealed he uses a dycem mat during dining.

Interview on 1/21/25 with the QIDP confirmed client #4 uses a dycem mat at meals.

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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 record review and interview, the facility failed to ensure written informed consent for restrictive behavior programs was obtained from the guardian. This affected 3 of 4 audit clients (#1, #3, and #5). The findings are: A. Review on 1/21/25 of client #1's Behavior Support Plan (BSP) dated 5/9/24 revealed an objective to exhibit 10 or fewer challenging behaviors per review period for 11 consecutive review periods. Additional review of the plan included the use of Ativan, Abilify, Prozac, Keppra, Tegretol and Melatonin to address the client's behaviors of aggression, inappropriate verbal behaviors, property destruction, self-injurious behavior, disruptive sleep hours, taking items not belonging to him and not making responsible choices. Further review of the record did not include written informed consent from the guardian for the BSP. Interview on 1/21/25 with the Qualified Intellectual Disabilites Professional (QIDP) confirmed no written informed consent had been obtained for client #1's BSP from her guardian. B. Review on 1/21/25 of client #3's Behavior Support Plan (BSP) dated 11/6/24 revealed an objective to exhibit 3 or fewer challenging behaviors per month for 11 consecutive review months. Additional review of the plan included	W 263		

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W 263	Continued From page 11 the use of Trazodone, Hydrochloride, Geodon and Depakote to address the client's aggressive behaviors. Further review of the record did not include written informed consent from the guardian for the BSP. Interview on 1/21/25 with the QIDP confirmed no written informed consent had been obtained for client #3's BSP from her guardian. C. Review on 1/21/25 of client #5's Behavior Support Plan (BSP) dated 1/6/25 revealed an objective to exhibit 1 or fewer challenging behaviors per review period for 11 consecutive review periods. Additional review of the plan included the use of Abilify, Ativan, Phenytoin, Zonegran, Vimpat, Onif, Diamox Sequel, Keppra, and Diazepam (PRN) to address the client's behaviors of unfounded accusations, depressive/psychotic symptoms, and making responsible choices. Further review of the record did not include written informed consent from the guardian for the BSP. Interview on 1/21/25 with the QIDP confirmed no written informed consent had been obtained for client #5's BSP from her guardian.	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 review and interviews, the facility failed to ensure a technique to address client #1's inappropriate behavior was	W 288		

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W 288	Continued From page 12 included in a formal active treatment plan. This affected 1 of 4 audit clients. The finding is: During observations in the home on 1/21/25, client #1's grooming bin containing various grooming products (i.e. body wash, toothpaste, deodorant, etc.) was kept locked in the laundry room. Interview on 1/21/25 with Staff B revealed client #1's grooming bin was being kept locked in the laundry room because he will throw them away. Review on 1/21/25 of client #1's Behavior Support Plan (BSP) dated 5/9/24 revealed an objective to address challenging behaviors. Additional review of the plan did not include a technique of locking client #1's grooming bin to address his inappropriate behaviors. Interview on 1/21/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's bin should not be kept locked as this technique was not included in his BSP.	W 288		
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 observation, record review and interviews, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 3 clients (#1) observed receiving medications. The finding is:	W 368		

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PINE RIDGE GROUP HOME	739 ARTHUR MADDOX ROAD SANFORD, NC 27330

(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 368	Continued From page 13 During observations of medication administration in the home on 1/21/25 at 3:17pm, client #1 received one drop of Yuletide .024% solution in each eye. Review on 1/21/25 of client #1's physician's orders signed 12/13/24 revealed an order for Yuletide .024% opt solution, instill one drop into both eyes at 6:00pm. Interview on 1/21/25 with the medication technician (Staff A) revealed she had given client #1 his eye drops early because she could not be sure if the staff coming in later were certified to give medications. Interview on 1/21/25 with the facility nurse indicated medications can only be given one hour before the scheduled time or one hour after.	W 368		