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	34G232	A. BUILDING _____ B. WING _____	01/28/2025

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NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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

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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 1/27/25 of the facility's EP plan training dated 5/14/24 did not indicate all new and/or existing staff had received training and/or retraining on the EP plan. Interview on 1/28/25 with the Home Manager (HM) revealed some staff working in the home had received training on the EP plan on 5/14/24; however, all staff were not included in the training. Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the Home Manager should be conducting training on the facilty's EP plan for new and existing staff.	E 037		
W 000	INITIAL COMMENTS A complaint investigation was conducted during the recertification survey on 1/27 - 1/28/25 for intake #NC00226214. The allegation was substantiated with no deficiencies cited. However,	W 000		

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W 000	Continued From page 5 the recertification survey resulted in cited deficiencies.	W 000		
W 229	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(i) The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the objectives statements for 1 of 5 audit clients (#4) were written with a single behavioral outcome. The findings is: Review on 1/27/25 of client #4's Individual Program Plan (IPP) dated 11/8/4 revealed the following objectives (all implemented 12/1/24): - refrain from urinating outside of the window at the group home and use the bathroom properly with no more than 3 verbal prompts 65% of the time for 12 consecutive months - complete his dental routine (brushing and flossing) with no more than 3 verbal prompts 60% of the time for 12 consecutive months - undress at night putting dirty clothes in a hamper and choosing his sleep attire after his shower before bed each night with no more than 3 verbal prompts 60% of the time for 12 consecutive months Additional review of the objective statements did not identify a single behavioral outcome. Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client	W 229		

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W 229	Continued From page 6 #4's objectives did not identify a single behavioral outcome.	W 229		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included specific interventions to support the use of his eye glasses. This affected 1 of 5 audit clients (#4). The finding is: During observations at the day program on 1/27/25, client #4 did not wear eye glasses. The client was not prompted or encouraged to wear eye glasses. Interview on 1/28/25 with client #4 revealed he wears eye glasses all the time. Interview on 1/28/25 with Staff C indicated client #4 wears his glasses all the time. Review on 1/27/25 of client #4's vision exam report dated 12/13/23 revealed he has astigmatism, myopia, and cataracts. The report also noted he has a prescription for glasses. Additional review of client #4's IPP dated 11/8/24 revealed no information regarding his eye glasses or their use. Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's IPP does not include any specific information	W 240		

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W 240	Continued From page 7 regarding his eye glasses or their use.	W 240		
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 reviews 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 area of meal preparation, leisure and behavior plan implementation. This affected 4 of 5 audit clients (#2, #4, #5 and #6). The findings are: A. During observations in the home on 1/27 - 1/28/25, Staff F and Staff K were noted preparing food items for the breakfast, lunch and dinner meals. No clients were observed to assist with the preparation of any food or drink items. Interviews on 1/27 - 1/28/25 with Staff F and Staff K revealed the clients do not assist with any cooking tasks in the home. Both staff indicated, with the exception of setting the table, they had not been trained to have clients assist with any other meal preparation tasks.	W 249		

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W 249	Continued From page 8 Review on 1/28/25 of client #2's 2024 Adaptive Behavior Inventory (ABI) revealed he can independently prepare beverages and sandwiches, identify fruits, vegetables, dairy products, meats, breads/cereals and identify/use kitchen equipment. Additional review of the ABI noted he has partial independence with selecting the four basic food groups for balanced meals, using measuring cups/spoons, operating burners on the stove, interpreting pictorial recipes and broiling/baking basic foods. Review on 1/28/25 of client #4's IPP dated 11/8/24 revealed he can identify kitchen equipment, use a microwave with assistance, and follow simple directions. The plan noted, "Staff should encourage [Client #4] to participate in household chores such as preparing meals...cooking..." Additional review of client #4's ABI dated 11/30/24 revealed he can independently prepare sandwiches, identify fruits, vegetable, dairy products, meats and breads/cereals. The ABI noted he requires partial independence to prepare a beverage, make salads, make desserts, prepare convenience foods, fry/broil/bake basic foods, and plan/prepare meals. Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be encouraging clients to assist with cooking tasks and assisting them as needed. B. During evening observations in the home on 1/27 - 1/28/25 from 3:43pm - 6:35pm, all six clients in the home were assigned a staff person to provide one-on-one monitoring. From 5:20pm -	W 249		

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W 249	Continued From page 9 5:54pm, Staff H and Staff J sat in the living room playing a block stacking game and a chess game with each other. During this time, their assigned clients, client #2 and client #5, were not engaged with any activities. Client #2 wondered around the living room while client #5 was asleep in a nearby chair. Interview on 1/28/25 with the Home Manager (HM) indicated all of the clients are assigned a one-on-one staff who should be assisting them during the shift and that staff only works with that particular client. Review on 1/28/25 of client #2's Behavior Support Plan (BSP) dated 1/14/24 revealed, Team members agreed that [Client #2] will have a one-on-one staff at all times." Additonal review of the plan noted, "[Client #2] tends to do best, and he is more likely to participate when he is provided choices of activities. Therefore, allow choices and decision making whenever possible....always offer choices..." The BSP indicated, "[Client #2] needs a lot of prompting and assistance with daily living skills." Review on 1/28/25 of client #5's record revealed monitoring guidelines dated 3/19/24. The guidelines indicated, "[Client #5] will be assigned a One-on-One staff during waking hours...for Monitoring and Supervision purposes ONLY...If you are [Client #5's] one-on-one, you are responsible for ALL [Client #5's] needs..." Interview on 1/28/25 with the QIDP confirmed staff should be interacting with and monitoring their assigned clients on their shift and not playing games without them.	W 249		

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W 249	Continued From page 10 C. B. During evening observations in the home on 1/27 - 1/28/25 from 3:43pm - 6:35pm, all six clients in the home were assigned a staff person to provide one-on-one monitoring. From 4:50pm - 4:56pm, client #6 was noted in his bedroom alone. During this time, Staff G, his assigned staff, was in another area of the home and sporadically walked past the bedroom door. Interview on 1/28/25 with the Home Manager (HM) indicated all of the clients are assigned a one-on-one staff who should be assisting them during the shift and that staff only works with that particular client. Review on 1/27/25 of client #6's BSP dated 7/8/24 revealed an objective to address behaviors of aggression, property destruction, AWOL, attempted AWOL, SIB, pica, severe disruption and failing to make responsible choices. Additional review of the plan noted as a preventative measure, a one-on-one staff person had been assigned to client #6. Interview on 1/28/25 with the QIDP confirmed client #6 has a one-on-one staff assigned throughout the shift. The QIDP noted whenever you see client #6, you should see his assigned staff.	W 249		
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 observations, record review and interview, the facility failed to ensure all	W 369		

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W 369	Continued From page 11 medications were administered without error. This affected 1 of 5 clients (#4) observed receiving medications. The finding is: During observations of medication administration in the home on 1/28/25 at 7:29am, client #4 was administered thirteen medications and eye drops. No additonal medications or topicals were administered at this time. Review on 1/28/25 of client #4's physician's orders (signed 11/18/24) revealed and order for Flonase 50mcg, instill one spray into each nostril twice daily at 8am and 8pm. Additional review of the orders noted Ocusoft Pre-moist pads should be applied to his eye lids once daily at 8am. Interview on 1/28/25 with the facility nurse confirmed client #4 should continue to receive Flonase and the Ocusoft pads daily as ordered.	W 369		
W 454	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 observation and interviews, the facility failed to ensure a clean and sanitary environment was maintained. This potentially affected all clients residing in the home. The finding is: During morning observations in the home on 1/28/25 at 6:59am, client #6 had a toileting accident while seated on the couch in the living room. The client's clothing and the cushion on the couch were soiled with urine. Staff D left the area	W 454		

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W 454	Continued From page 12 with client #6 to change his clothing and later returned to the living room with a paper towel. The staff used the paper towel to wipe the urine off the couch cushion. No cleaning agents were used to clean and/or disinfect the couch. At 7:07am, client #6 was prompted to return to the same seat on the couch. Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed after a toileting accident, the staff should "sanitize" the couch cushion and/or remove it. Interview on 1/28/25 with the Nurse B confirmed urine should be cleaned with a cleaning solution .	W 454		
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 2 of 5 audit clients (#3 and #4) received their specially-prescribed diets. The findings are: A. During dinner observations in the home on 1/27/25 at 6:01pm, client #4 served himself a single serving of all food items including five chicken tenders, carrots, pinto beans, and ice cream. During breakfast observations in the home on 1/28/25 at 7:38am, client #4 served himself a single serving of oatmeal, one slice of toast, and one cup of applesauce.	W 460		

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W 460	Continued From page 13 Interview on 1/27 - 1/28/25 with Staff F and Staff K revealed they follow specific diets posted on the refrigerator in the home (which indicated client #4 receives double portions at meals). Review on 1/27/25 of client #4's Nutritional Evaluation dated 10/28/24 revealed he consumes a regular heart healthy diet with "double portions at all meals". Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 should be served double portions at meals as indicated. B. During observations of medication administration in the home on 1/28/25 at 7:19am, client #3 ingested his medications with water. The water was not thickened. Review on 1/27/25 of client #3's Nutritional Evaluation dated 9/20/24 noted he consumes a regular consistency diet with "honey thick liquids". Interview on 1/28/25 with the Home Manager (HM) indicated client #3 should have his medication with applesauce or thickened water. Interview on 1/28/25 with the QIDP confirmed client #3 should ingest thickened liquids as indicated.	W 460		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations, document review and	W 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G232	A. BUILDING _____ B. WING _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENTIAL	68 MITCHELL FORD ROAD CLARKTON, NC 28433

(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 481	Continued From page 14	W 481		

interviews, the facility failed to ensure a record of food actually served was kept. The finding is:

During lunch observations at the day program on 1/27/25 at 11:44am, clients consumed pudding cups or jello cups instead of pears as noted on the weekly menu. During breakfast observations in the home on 1/28/25 at 7:38am, clients were not served yogurt as identified on the weekly menu.

During additional observations in the home on 1/28/25, Staff K prepared turkey sandwiches for the client's lunch meals later that day. Closer observation of the lunch bags also revealed pudding, jello or applesauce. Review of the lunch menu for the day noted ravioli with tomato sauce, potato salad, rolls, mandarin oranges and a beverage.

Further review of the menu book located in the home did not reveal any documented food substitutions.

Interview on 1/28/25 with Staff K revealed they do not document food substitutions for the home.

Interview on 1/28/25 with the Home Manager (HM) confirmed no record of food substitutions is kept for the home.

Interview on 1/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be documenting all food substitutions based on the menu.