STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G250	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEFIELD HOME	730 FISHER RIDGE DRIVE MONROE, NC 28110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 1/23/25 for intake #NC00226070 and #NC00226077. The allegations were substantiated and deficiencies were cited.	W 000		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete the Health Care Personnel Registry (HCPR) within 5 business days as required by state statue. The finding is: Record review on 1/23/25 during a complaint survey revealed a facility incident report dated 1/6/25 of an allegation of physical abuse. Further review revealed client #1 was spitting and hitting others. Review of the NC Incident Response Improvement System (IRIS) report dated 1/8/25 revealed staff A put client #1 in an unauthorized restraint/hold. Staff A wrapped his arms and legs around client #1. Staff A had not received restrictive intervention training at the facility and no other interventions were used on client #1 to de-escalate his behaviors. There were no injuries during the restraint from Staff A. Staff A was suspended pending investigation. Continued review revealed an internal investigation was initiated on 1/8/25 and was still pending/incomplete during the survey. Interview with the I/DD State Coordinator (SC) on 1/23/25 confirmed that the HCPR 5-day report	W 156		

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

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W 156	Continued From page 1 was not completed within five business days of the incident and is currently incomplete. The I/DD SC stated that he was unaware that the HCPR 5-day report was required and completed the IRIS report.	W 156		
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 clients received a continuous active treatment program consisting of needed behavioral interventions and services as identified in the person-centered plan (PCP) for 1 of 3 sampled clients (#1). The finding is: A complaint investigation survey was completed on 1/23/25 to address the allegations. The following documentation was reviewed during the survey: staff scheduling from 1/1/2025-present, nurse's notes, QIDP documentation, IRIS reports, incident reporting from 10/2024-1/2025, disciplinary action personnel documentation, staff in-service training, facility personnel policies, investigations and incident reporting policies.	W 249		

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W 249	Continued From page 2 Review of facility documentation on 1/23/25 revealed an IRIS report dated 1/9/25 which indicated that on 1/6/25 around 4:16 PM a staff member placed client #1 in an unapproved restrictive hold to prevent the client from being physically aggressive to other persons in the facility. Continued review of the IRIS report revealed staff are not trained in restrictive interventions and staff reports vary relative to how the client was held in a restrictive holding position. Additional review of the IRIS report did not indicate that a 5-day health care personnel registry report was completed. Review of the record for client #1 on 1/23/25 revealed a behavior support plan (BSP) dated 12/11/24 which indicated the following target behaviors: physical and verbal aggression, property destruction, and self-injurious behaviors (SIBs). Continued review of the BSP for client #1 revealed interventions relative to physical aggression (i.e. hitting, kicking, fighting, throwing object with the intent to hit someone) indicated staff should verbally redirect the client to an activity and keep other persons away from the client. Subsequent review of the record for client #1 revealed a treatment team meeting note dated 12/4/24 which indicated that a team meeting was held to further discuss client behaviors and the need for a 1:1 staff. Facility will be implementing a 1:1 staff to assist with challenging behaviors. Staff will remain within arms reach of client during waking hours. Staff will receive in-service training relative to client #1's BSP updates. Review of the facility documentation revealed an in-service training dated 1/8/25 indicating that two facility staff have received in-service training to date	W 249		

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W 249	Continued From page 3 relative to client #1's BSP changes. Additional review of facility documentation revealed an agency restrictive intervention policy dated 12/16/24 which indicated "restrictive interventions will not be allowed on a planned basis in an individual's plan. Violations of this policy shall be investigated as abuse, and will result in discipline, up to and including termination of employment". Review of facility documentation did not reveal that the approved interventions and objectives were used to de-escalate client #1's behavior. Interview with the I/DD State Coordinator (SC) on 1/23/25 revealed that the facility has a no hands policy relative to restrictive interventions. Continued interview with the I/DD SC revealed that staff have not received restrictive intervention training to be used to de-escalate behaviors. Further interview with the I/DD SC revealed staff should use the approved interventions and technical objectives relative to client #1's behaviors in his BSP.	W 249		