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 _____	C 03/24/2025

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 000	INITIAL COMMENTS A complaint survey was completed on 3/24/25 for intake #NC00227632. Although allegations were unsubstantiated, deficiencies were cited not related to the allegations.	W 000		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide sufficient direct care staff to manage and supervise 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Observations in the facility on 3/24/25 at 6:20AM revealed Staff A and Staff B on duty with six clients in the facility. Further observations at 7:00AM revealed Staff A to sit in the medication room with a client and Staff B to sit at the table with the five remaining clients. Continued observations revealed Staff B to announce that she was leaving for the day and left the premises. Subsequent observations revealed Staff A to remain with the six clients until Staff C entered the facility at 7:20AM for duty. Interview with Staff A on 3/24/25 indicated that there should be two staff with the six clients and a third staff would be on duty at 7:00AM. Further interview with Staff A verified that third shift staff usually remain on shift until 9:00AM.	W 186		

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

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W 186	Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) verified the staffing schedule that Staff B should have remained on shift until 9:00AM. Further interview with the QIDP verified that two clients (#1, #5) require 1:1 staff supervision during waking hours. Continued interview with the QIDP revealed that there should be at least two staff on each shift (1st, 2nd, and 3rd). Additional interview with the QIDP verified by operating with only 1 staff during the 20 minutes left the facility out of compliance with the agency staffing guidelines.	W 186		
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 interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 6 (#3) clients. The finding is: Observations on 3/24/25 at 7:17AM revealed client #3 to sit at the dining room table to participate in the breakfast meal. Further observation revealed Staff A to pour client #3 some juice and place it in front of the client. Continued observation revealed client #3 to drink the juice without thick-it powder added. Subsequent observation at 7:23AM revealed staff A to pour client #3 a second cup of juice and add the thick-it powder to the cup, immediately handing the cup to the client to drink without allowing the drink to thicken. At no point during	W 368		

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W 368	Continued From page 2 the observation did staff provide client #3 with liquids at a nectar thick consistency as prescribed. Review of the record for client #3 on 3/24/25 revealed a physician's order dated 3/14/25. Further review of the 3/2025 physician's order indicated that client #3 should have nectar thick liquids. Interview with facility nursing and the qualified intellectual disabilities professional (QIDP) on 3/24/25 verified client #3's diet order is current. Further interview with the facility nurse and QIDP revealed that staff should prepare client #3's liquids at a nectar thick consistency as prescribed.	W 368		
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 assure all drugs were administered without error for 1 of 6 clients (#5). The finding is: Observations on 3/24/25 at 7:05AM revealed Staff A to call client #5 to the medication room to prepare for medication administration. Further observation revealed Staff A to pull out client #3's medications and punch them into a medication cup without client assistance. Continued observations revealed Staff A to place the following medications in the cup: Levothyroxine 150mcg., Aripiprazole 5mg, and Vitamin D3 400	W 369		

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W 369	Continued From page 3 IU. Subsequent observations revealed client #3 to take the medications together with water. Observations did not reveal client #5 to take the Levothyroxine medication as prescribed. Review of the record for client #5 on 3/24/25 revealed a physician's order dated 3/12/25 which indicated that the client should take Levothyroxine medication without any other medications and at least 30 minutes before eating any food. Interview with the facility nurse on 3/24/25 revealed staff should have provided client #5 with the Levothyroxine medication before any other medications as prescribed. Interview with the qualified intellectual disabilities professional (QIDP) on 3/24/25 revealed client #5 is capable of participating in medication administration. Further interview with the facility nurse and QIDP revealed staff should have provided medication education to include the dosage, frequency, and side effects of the medication. Subsequent interview with the QIDP revealed staff have been trained to administer medications for clients as prescribed.	W 369		
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 observation and interviews, the facility failed to assure all medications and biologicals remained locked except when being prepared for medication administration for 1 of 6 clients (#5). The finding is:	W 382		

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W 382	Continued From page 4 Observations on 3/24/25 at 7:00AM revealed Staff A to enter the medication room to prepare for medication administration. Further observations revealed Staff A to prompt client #5 to enter the medication room. Continued observations at 7:10AM revealed Staff A to exit the medication room, leaving client #5 inside of the room. Subsequent observations revealed client #5 to remain in the medication room with the medication cabinet open. Observations also revealed client #5 to remain in the medication room unattended with a medication basket on the counter for a total of 10 minutes. Additional observations at 7:20AM revealed Staff A to return to the medication room to resume medication administration for client #5. Interview with the facility nurse and qualified intellectual disabilities professional (QIDP) on 3/24/25 verified that client #5 should not have been left unattended in the medication room. Further interview with the facility nurse and QIDP revealed that staff should have secured the medications and prompted client #5 to exit the medication room until the staff could resume medication administration. Subsequent interview with the facility nurse and QIDP verified staff have been trained to secure medications when they are not being administered to the clients.	W 382		