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

PRINTED: 08/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G155	A. BUILDING _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST I & II	421 RIDGECREST AVENUE WEST JEFFERSON, NC 28694

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure the right of dignity for 1 of 7 audited clients (#10) in relation to the use of incontinence padding. The finding is: Observations in the group home 8/5-6/25 revealed an incontinent pad to be visible in the living room located under the cushion of the couch. Continued observation revealed the incontinent pad could be seen hanging off the couch. Interview on 8/6/25 with Direct Support Mentor (DSM) revealed that an incontinence pad was placed under the cushion of the couch due to client #10 taking naps on the couch. Further interview with the DSM revealed that client #10 urinates during his naps and the incontinence pads are in place for that reason. Continued interview the DSM revealed that the couch has a strong smell of urine.	W 125	W 125 The Administrator will in-service the QIDP and direct support staff regarding people supported rights to have appropriate incontinence coverings used in the homes. Clinical team will monitor appropriate protective coverings by completing 2 Interaction Assessments per week for a period of 1 month and then on a routine basis. In the future the Qualified Professional will ensure all people supported have appropriate incontinence protective coverings by following ongoing QA monthly assessments. By: October 5th, 2025	
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	W 249		

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

Lucy Rominger IDD Administrator 8/20/25

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 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to assure a continuous active treatment program identified as an individual need was implemented for 3 of 7 audited clients (#8, #11, and #12) relative to Occupational Therapy (OT) Evaluation guidelines during mealtimes. The findings are: A. The facility failed to follow OT guidelines for client #8 during mealtimes. For example: Observations in the group home on 8/5-6/25 revealed client #8 to consume the entire dinner meal and breakfast meal. Further observations revealed the client eating his meals with a high-side divided dish and a small spoon. Continued observations revealed client #8 to eat his meals at a fast rate. At no time during observations did staff prompt the client to slow down and no staff at the dining table during breakfast. Review of records for client #8 on 8/6/25 revealed a person-centered plan (PCP) dated 3/31/25. Further review of the PCP revealed an OT evaluation dated 12/11/23 for the client to use a small spoon or maroon spoon and a high side divided dish as adaptive equipment to decrease the client from overstuffing spoon and overstuffing mouth. Interview with the qualified intellectual disabilities professional (QIDP) verified that client #8's PCP	W 249	W 249 A, B, and C The QIDP will meet with the Clinical team to determine if any changes are needed to client #8, #11 and #12's OT guidelines. Including any determined changes, QIDP will in-service all staff on clients' OT guidelines and Clinical team will monitor to ensure all OT guidelines are followed by 2 Mealtime Assessments a week for 1 month and then on a routine basis. In the future the team will ensure OT guidelines are followed by ongoing monthly QA assessments. By: October 5th, 2025	

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W 249	Continued From page 2 was current. Further interview with the QIDP confirmed that staff should monitor client #8's rate of eating. B. The facility failed to follow OT guidelines for client #11 during mealtimes. For example: Observations in the group home on 8/5-6/25 revealed client #11 to consume the entire dinner meal and breakfast meal. Further observations revealed the client to eat his meals with a high-side divided dish and a maroon spoon. Continued observations revealed client #11 to eat his meals at a fast rate and to stack his food on the maroon spoon using his opposite hand to stuff his mouth. At no time during observations did staff prompt the client to slow down and no staff at the dining table during breakfast. Review of records for client #11 on 8/6/25 revealed a PCP dated 4/29/25. Further review of the PCP revealed an OT evaluation dated 10/5/25 for the client to be provided verbal prompts to slow down and to use his utensils instead of his fingers when eating and drinking as needed. Interview with the QIDP verified that client #11's PCP was current. Further interview with the QIDP confirmed that staff should monitor client #11's rate of eating and provide prompts to slow down. C. The facility failed to follow OT guidelines for client #12 during mealtimes. For example: Observations in the group home on 8/5-6/25 revealed client #12 to consume the entire dinner meal and breakfast meal. Further observations revealed the client to eat his meals with a high-side divided dish and a maroon spoon.	W 249		

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W 249	Continued From page 3 Continued observations revealed client #12 to eat his meals at a fast rate and to stuff his mouth. At no time during observations did staff prompt the client to slow down and no staff at the dining table during breakfast. Review of records for client #12 on 8/6/25 revealed a PCP dated 4/29/25. Further review of the PCP revealed an OT evaluation dated 11/25/24 for the client to be provided verbal prompts to slow down when eating and to take sips intermittently throughout the meal. Interview with the QIDP verified that client #12's PCP was current. Further interview with the QIDP confirmed that staff should monitor client #12's rate of eating and follow the prescribed guidelines.	W 249		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at varied times on first shift and second shift in Ridgecrest I and II. The findings are: A. Review on 8/5/25 of Ridgecrest I fire drills conducted August 2024 - July 2025 revealed the following: First shift drills were conducted on 10/2/24 at 7:15am, 1/10/25 at 7:20am, 4/10/25 at 9:30am, 7/30/25 at 1:20pm. Second shift drills were conducted on 8/21/24 at 3:24pm, 11/6/24 at 4:18pm, 2/12/25 at 6:40pm, 5/28/25 at 5:38pm.	W 441	W 441 The IDD Administrator will in-service the QIDP and the Direct Support Supervisor on the Fire Drill schedule requirements to include ensuring requirements for the drills to occur under varied conditions/times. QIDP/DSS will perform an additional fire drill at a varied time on both 1st and 2nd shift for 1 month. This will be monitored by QP reviewing the monthly fire drills and will ensure that they are varied. In the future all fire drill documentation will be monitored by the QP correctly and provided to the IDD Administrator by monthly Quality Assurance meetings. By: October 5th, 2025	

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W 441	Continued From page 4 B. Review on 8/5/25 of Ridgecrest II's fire drills conducted July 2024 - June 2025 revealed the following: First shift drills were conducted on 7/27/24 at 9:00am, 10/1/24 at 11:03am, 1/2/25 at 11:10am and 4/10/25 at 9:00am. Second shift drills were conducted on 8/21/24 at 4:00pm, 11/5/24 at 3:20pm, 2/7/25 at 4:00pm and 5/28/25 at 5:07pm. Interview on 8/6/25 with the qualified intellectual disabilities professional (QIDP) revealed first shift hours are 7:00am - 3:00pm, and second shift hours are 3:00pm - 9:00pm and/or 3:00pm - 11:00pm. Continued interview with the QIDP confirmed fire drills should be conducted under varied times throughout first and second shifts.	W 441		