

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

PRINTED: 01/14/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER PINE RIDGE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 039	<p>EP Testing Requirements CFR(s): 483.475(d)(2)</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by</p>	E 039			

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 039	<p>Continued From page 1</p> <p>a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using</p>	E 039			

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E 039	Continued From page 2 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039			

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E 039	<p>Continued From page 3</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p>	E 039			

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039			

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E 039	<p>Continued From page 5</p> <p>test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that</p>	E 039			

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E 039	<p>Continued From page 6 is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p>	E 039			

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E 039	<p>Continued From page 7</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared</p>	E 039			

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E 039	<p>Continued From page 8</p> <p>questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a full scale exercise, mock drill or an annual table top activity was conducted and included in the facility's Emergency Preparedness Plan (EPP). The finding is:</p> <p>Review on 1/12/26 revealed no evidence of an annual tabletop, full scale exercise or mock drill being completed within the past year.</p> <p>Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the</p>	E 039			

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E 039 W 130	Continued From page 9 facility was unable to show documentation detailing any exercises to test their EPP . PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure clients were afforded privacy during medication administration. This affected 3 of 5 audit clients (#1, #2, and #4). The findings are: A. During medication administration observation on 1/13/26, at 7:00am, Staff D administered all medications and ear drops to client #1 with the door open to the hallway/kitchen area. Staff, and other clients in the home, were observed to walk throughout the hall during the medication administration. B. During medication administration observation on 1/13/26, at 7:05am, Staff D administered all medications to client #2 with the door open to the hallway/kitchen area. Staff, and other clients in the home, were observed to walk throughout the hall during the medication administration. C. During medication administration observation on 1/13/26, at 7:15am, Staff D administered all medications and nasal sprays to client #4 with the door open to the hallway/kitchen area. Staff, and other clients in the home, were observed to walk throughout the hallway during the medication administration.	E 039 W 130			

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W 130	Continued From page 10 Review on 1/13/26 of the facility medication administration procedure revealed privacy should be ensured during medication administration and care. Interview on 1/13/26 with the facility nurse revealed the medication administration rooms are small, but staff should ensure doors are closed during administration of medicine and care for privacy, particularly if others are walking in the hallway. Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff should close the medication room door or kitchen door to ensure privacy during medication administration.	W 130			
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 Individual Program Plan (IPP) objectives were written in terms of a single behavioral outcome. This affected 1 of 5 audit clients (#3). The finding is: Review on 1/12/26 of client #3's IPP dated 5/5/25 revealed an objective which was not written with a single behavioral outcome. The objective noted, he "will follow a regular laundry routine more independently, as well as notify staff when his laundry is full or needs to be washed by 5/4/26. Further review revealed an objective noting, he	W 229			

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W 229	Continued From page 11 "will shower and complete oral hygiene tasks with minimal staff assistance by 5/4/26.	W 229			
W 248	<p>Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #3's objectives should be written for one skill outcome. She confirmed that his objectives were written for more than one outcome and should be revised.</p> <p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7)</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure current Individual Program Plans (IPP's) and Behavior Support Plans (BSP's) were available to all relevant staff. This affected 3 of 5 audit clients (#2, #3 and #4). The findings are:</p> <p>A. Review on 1/12/26 of the IPP and BSP notebook revealed there was not an updated IPP for client #2. Further review revealed the IPP that was in the notebook was from 2024, and no further updated IPP could be located for staff to reference in the facility online data system.</p> <p>B. Review on 1/12/26 of the IPP and BSP notebook revealed there was not an updated IPP and BSP for client #3. Further review revealed the ISP in the notebook was dated 12/7/24, and no further updated IPP could be located for staff reference in the facility online data system.</p>	W 248			

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NAME OF PROVIDER OR SUPPLIER PINE RIDGE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 248	Continued From page 12 Additionally, the BSP that was in the notebook was dated 2024. C. Review on 1/12/26 of the IPP and BSP notebook revealed there was not an updated IPP and BSP for client #4. Further review revealed the ISP in the notebook was dated 5/3/24, and no further updated IPP could be located for staff reference in the facility online data system. Additionally, the BSP that was in the notebook was dated 2024. Interview on 1/12/26 with Staff E revealed the books are out of date, but the information should be in the online data system. During interview on 1/12/26 with the Program Manager, she confirmed the notebooks were out of date, and the updated plan information for clients #2, #3, and #4 could not be located in the online data system. Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed all clients' plans should be in the books in the home and in the online system, but some have disappeared with management changes. Client #2, #3, and #4's IPP's and BSP's were not updated in either the notebook or the online data system and available for relevant staff. Further interview revealed the notebooks and online system are used by staff if they have any questions about the clients' program plans and behaviors.	W 248			
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249			

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W 249	<p>Continued From page 13</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 audit clients (#4) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of falls prevention guidelines. The finding is:</p> <p>Observation in the home throughout 1/12/26 and 1/13/26 revealed client #4 in his wheelchair. Staff were not observed to complete circulation checks every 30 minutes while in his chair or remove his belt every 1.5 hours.</p> <p>Review on 1/12/26 of client #4's IPP, dated 5/3/24, revealed he is diagnosed with cerebral palsy and scoliosis. He uses a wheelchair for ambulation.</p> <p>Review on 1/12/26 of client #4's fall prevention guidelines, dated 8/16/25, revealed he is at a high falls risk, with mild to moderate risk for pressure ulcers. Falls prevention guidelines should be followed to include time out of chair and circulation checks.</p> <p>Review on 1/13/26 of client #4's Behavior Support Plan (BSP), dated 12/30/24, revealed he should</p>	W 249			

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W 249	Continued From page 14 receive circulation checks every 30 minutes while in his chair. He should wear his belt for 1.5 hours, and then staff should remove his belt for 30 minutes while performing circulation checks. Staff should remain with him 1:1 during the 30 minute check. Interview on 1/12/26 with Staff D revealed client #4 is out of the chair sometimes but always has his belt on. Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff should follow client #4's guidelines for his BSP and falls prevention guidelines. Client #4 should be out of his chair at regular intervals, and his circulation should be checked during those 30 minutes every two hours. The QIDP confirmed that staff may not be following the circulation checks with 1:1 supervision during these checks.	W 249			
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 1 of 5 audit clients (#3). The finding is: Review on 1/13/26 of client #3's Individual	W 252			

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W 252	<p>Continued From page 15</p> <p>Program Plan (IPP) dated 5/5/25 revealed formal training programs as follows:</p> <ul style="list-style-type: none"> - will participate in meal prep twice a week to help improve home living skills - will follow a regular laundry routine more independently, as well as notify staff when his laundry is full or needs to be washed - will perform an exercise regimen daily on either shift due to weight gain to promote healthy living - will help complete household chores more independently, to include taking out trash, loading the washer, and cleaning up area after meal time - will shower and complete oral hygiene tasks with minimal staff assistance <p>Review on 1/13/26 of client #3's training documentation from revealed for the months of November and December, 2025 and January, 2026, documentation was consistently collected by staff for training goals. However, data consisted of noting a skill had been completed with no measurable terms applied to the objectives.</p> <p>Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #3's training objectives were co-written with the former QIDP. The QIDP confirmed that the objectives were not written in measurable terms for monitoring progress, and the staff were unable to document progress in measurable terms.</p>	W 252			
W 260	<p>PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2)</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p>	W 260			

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W 260	Continued From page 16 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update the Individual Program Plan (IPP) annually as required for 2 of 5 audit clients (#2 and #4). The findings are: A. Review on 1/12/26 of client #2's record revealed an IPP dated 12/17/24. Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed a meeting had been completed for client #2 on 12/16/25, but the IPP could not be located. B. Review on 1/12/26 of client #4's record revealed an IPP dated 5/3/24. Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she could not locate an updated IPP for client #4.	W 260			
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: The facility failed to assure fire drills were conducted quarterly for each shift of personnel as evidenced by interview and record verification. This potentially affected all clients (#1, #2, #3, #4, and #5) residing in the home. The finding is: Review on 1/12/26 of the facility's fire drill evacuation reports for 1/1/25 through 12/31/25 revealed there was no first shift fire drill conducted for the quarter of 1/1/25 - 3/31/25. No third shift fire drills were conducted for quarters dated 4/1/25 - 12/31/25.	W 440			

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W 440	Continued From page 17 Interview on 1/12/26 with the Program Manager revealed she had started working at the home within the past three months and could not locate further fire drill reports.	W 440			
W 441	Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed there were no further fire drill reports. EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all clients (#1, #2, #3, #4, and #5) residing in the home. The finding is: Review on 1/12/26 of fire drill reports revealed fire drills were not conducted at varied times throughout the shifts. The fire drill reports revealed the following: First Shift: 1/14/25 - 8:20am 4/10/25 - 8:12am 7/14/25 - 8:35am Third Shift: 3/10/25 - 8:00am Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed fire drills should be conducted at varied times throughout shifts.	W 441			