		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		34G044	B. WING			07/	09/2019
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				5 EAST HEATH AVE		
				SI	MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 104	GOVERNING BOD CFR(s): 483.410(a)		W 10	04			
		y must exercise general policy, ing direction over the facility.					
	The governing bod ensure staff followe phone usage during	s not met as evidenced by: y and management failed to d a policy regarding cell y work hours as evidenced by terviews. The finding is:					
	Staff were using the work hours.	eir personal cell phone during					
	7/8/19 at 5:45pm, S her personal cell ph revealed Staff A wa	ervations in the home on Staff A was observed to be on hone. Further observations s standing in the bedroom of a nt was laying in his bed.					
		te interview, Staff A confirmed on their personal cell while					
	Mobile Devices in the stated, "employee work and should not	f the facility's policy Using he Workplace dated 10/1/17 es are expected to focus on htengage in personal use of e device in the workplace"					
W 189	disabilities profession should not being us during working hour	PROGRAM	W 1	89			
		ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 07/11/2019

		AND HUMAN SERVICES				FORM	: 07/11/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G044	B. WING			07/	/09/2019
NAME OF	PROVIDER OR SUPPLIER	•	-		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HEATH A	VENUE HOME				05 EAST HEATH AVE SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 189	The facility must prinitial and continuin employee to perfor efficiently, and com This STANDARD is Based on observat interviews, the facil sufficiently trained t and documenting in record. The finding 1. Staff were not eff documenting target During observations 5:50pm, client #4 w while he was at the person redirected h did. During an interview she did not know if support plan or not. she normally works working today beca schedule. During an interview (HM) revealed Staff behavior support pl including client #4. 2. Staff were not eff documenting on the During observations	ovide each employee with g training that enables the m his or her duties effectively, petently. s not met as evidenced by: tions, record review and ity failed to ensure staff were to document target behaviors in the medication administration gs are: ffectively trained regarding t behaviors. s in the home on 7/8/19 at vas hitting the side of his head dining room table. A staff him to finish eating; which he on 7/8/19, Staff A revealed client #4 had a behavior . Further interview revealed a tanother home and was huse she was put on the on 7/9/19, the home manager f A has been trained on the ans of the clients in the home, ffectively trained regarding		189			

		AND HUMAN SERVICES			FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G044	B. WING		07/0	09/2019
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HEATH A	VENUE HOME			05 EAST HEATH AVE MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 189	medications. During an interview she had signed off and #2 consuming stated she was only medications agains the clients consume During an interview the MAR is to be sig consume their med During an interview stated the MAR is " signed prior to the of medications. INDIVIDUAL PROG CFR(s): 483.440(c) Within 30 days afte interdisciplinary tea assessments or rea supplement the pre prior to admission.	nd #2 consuming their on 7/9/19, Staff B confirmed on the MAR prior to clients #4 their medications. Staff B y trained to check the at the MAR three times before ed their medications. on 7/9/19, the HM revealed gned off after the clients lications. on 7/9/19, the facility's nurse 'absolutely" not suppose to be clients consuming their BRAM PLAN 0(3) er admission, the im must perform accurate assessments as needed to eliminary evaluation conducted s not met as evidenced by: eview and interview, the facility eeded visual assessment for 1 nt (#2) no later than 30 days	W 189 W 210	DEFICIENCY)		
	for client #2 in a tim					

If continuation sheet Page 3 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G044	B. WING			07/0	09/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				05 EAST HEATH AVE MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 210	 plan (IPP) dated 10 admitted to the faci of client #2's record examination dated During an interview intellectual disabiliti confirmed client #2' completed within 30 facility. INDIVIDUAL PROG CFR(s): 483.440(c) The comprehensive include physical det This STANDARD is Based on record refailed to ensure 1 n received a physical The finding is: Client #2 did not refwithin 30 days of ad Review on 7/8/19 o physical examinatio review revealed clief facility on 8/28/18. During an interview intellectual disabilitit confirmed client #2' not completed within 	f client #2's individual program /2/18 revealed she was lity on 8/28/18. Further review revealed a visual 12/3/18. on 7/9/19, the qualified es professional (QIDP) 's visual examination was not 0 days of admission to the GRAM PLAN (3)(v) e functional assessment must velopment and health. s not met as evidenced by: eview and interview, the facility ewly admitted client (#2) within 30 days of admission.	W 2				
W 217	facility. INDIVIDUAL PROG	GRAM PLAN	W 2	217			

If continuation sheet Page 4 of 14

		AND HUMAN SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G044	B. WING			07/	09/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				05 EAST HEATH AVE MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 217	Continued From pa CFR(s): 483.440(c)	-	W 2	217			
	The comprehensive include nutritional s	e functional assessment must status.					
	Based on record re failed to ensure 1 n	s not met as evidenced by: eview and interview, the facility ewly admitted client (#2) nent was completed within 30 The finding is:					
	The facility failed to assessment for clie	o obtain a nutritional ent #2 in a timely manner.					
	plan (IPP) dated 10 admitted to the facil	of client #2's individual program 0/2/18 revealed she was 1lity on 8/28/18. Further review 1s nutritional assessment was 9.					
W 218	intellectual disabiliti confirmed client #2' not completed withi facility.		W 2	218			
	The comprehensive include sensorimote	e functional assessment must or development.					
	Based on record re facility failed to obta	s not met as evidenced by: eviews and interviews, the ain a needed sensorimotor ewly admitted client (#2) within on. The finding is:					

If continuation sheet Page 5 of 14

		AND HUMAN SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		34G044	B. WING _			07/	09/2019
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				95 EAST HEATH AVE MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 218	Continued From pa	ge 5	W 2	18			
		obtain an occupational sment for client #2 in a timely					
	plan (IPP) dated 10 admitted to the facil	f client #2's individual program //2/18 revealed she was lity on 8/28/18. Further review l revealed her OT assessment 12/4/18.					
W 221	intellectual disabiliti confirmed client #2		W 2:	221			
	The comprehensive include auditory fun	e functional assessment must actioning.					
	Based on record re failed to obtain in a	s not met as evidenced by: eview and interview, the facility timely manner a auditory ewly admitted client (#2) within on. The finding is:					
	The facility failed to for client #2 in a tim	obtain a auditory assessment nely manner.					
	plan (IPP) dated 10 admitted to the facil	f client #2's individual program //2/18 revealed she was lity on 8/28/18. Further review I revealed there is no record of assessment.					

If continuation sheet Page 6 of 14

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G044 B. WING 07/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **105 EAST HEATH AVE** HEATH AVENUE HOME SMITHFIELD, NC 27577 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 221 Continued From page 6 W 221 During an interview on 7/9/19, the gualified intellectual disabilities professional (QIDP) confirmed client #2's auditory assessment was not completed within 30 days of admission to the facility. W 249 **PROGRAM IMPLEMENTATION** W 249 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 2 of 3 audit clients (#2, #4) received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas appearance, self help and dining guidelines. The findings are: 1. Client #2 was not afforded the opportunity to wear properly fitted clothing. During morning observations in the home on 7/9/19 at 6:35am, client #2 stood up from a chair and her pants were hanging and loose on her hips. Further observations revealed client #2's undergarments were visible to anyone in the home. At 8:38am Staff C had client #2 change her pants. Client #2 came out of her bedroom

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 7 of 14

PRINTED: 07/11/2019

		AND HUMAN SERVICES				FORM	: 07/11/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		34G044	B. WING			07/	09/2019
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HEATH A	VENUE HOME				105 EAST HEATH AVE SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 249	 wearing a different observations those on her hips. Addition client #2's undergate in the home. During an interview staff person on third manager (HM) how fitting her. Review on 7/8/19 of stated, "[Client 2's] her." During an interview intellectual disabilitic confirmed client #22 loose on her hips. client #2 does not of 2. Client #2's meal During dinner obsecclient #2 was overss Further observation more food in her m inside of her mouth At no time was client food before putting Review on 7/9/19 of dated 12/12/18 state 	pair of pants. Upon further pants were hanging and loose onal observations revealed rments were visible to anyone on 7/9/19, Staff C revealed a d shift had told the home or client #2's pants were not f client #2's IPP dated 10/2/18 appearance is important to on 7/9/19, the qualified es professional (QIDP) 's pants were banging and Further interview revealed own belt. guidelines were not followed. rvations in the home on 7/8/19 tuffing her mouth with food. hs revealed as client #2 put outh, there was food visible that she had not swallowed. In #2 prompted to swallow her more in her mouth. f client #2's meal guidelines red, "Monitor for packing her age her to chew her foods and	W 2	249			
	staff should have p	on 7/9/19, the QIDP revealed rompted client #2 not to while she was eating.					

If continuation sheet Page 8 of 14

		AND HUMAN SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		34G044	B. WING			07/(09/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				05 EAST HEATH AVE MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 249	Continued From pa	ige 8	W 2	249			
	3. Client #4's feedin followed.	ng guidelines were not					
	client #4 ate his me	rvations in the home on 7/8/19 eal sixteen times with his s was client #4 prompted to					
	dated 8/13/07 revea prompts as needed	f client #4's feeding guidelines aled, "4. Provide verbal I to encourage [Client #4] to redirect any attempts of r feeding"					
W 252	staff should have pr spoon to eat with.		W 2	252			
	specified in client in	complishment of the criteria ndividual program plan documented in measurable					
	Based on observat interviews, the facili	s not met as evidenced by: tions, record reviews and ity failed to ensure data was ttly. This affected 1 of 3 audit iding is:					
	Data was not collec	cted as indicated for client #4.					
		servations in the home on lient #4 hit the side of his head					

If continuation sheet Page 9 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G044	B. WING			07/09/2019	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				05 EAST HEATH AVE SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 252	Continued From pa on seven separate kitchen. Further ob shift staff person wa Additional observat documented as ind Review on 7/9/19 o plan (BSP) dated 7. Self-Injurious Beha result in harm to se in the face" Furth "Documentation: requiring staff intervi- behaviors of clinica documented" Review on 7/9/18 o procedures dated J Support Data Shee occurrence of inapp expression. Such o a minimum, the dat description of the b revealed, "In additio Plans (BSP) may re- forms specific to the the plan"	ge 9 occasions while he was in the pservations revealed a third as also in the kitchen. ions revealed no data was icated. f client #4's behavior support /17/19 stated, "Response to vior: Any behavior that could lf (for examplehitting himself her review revealed, Episodes of self-injury vention as well as any other I concern should be f policy for documentation uly 2003 stated, "A Behavior t will be used to document the propriate behavioral documentation shall include, at e and time of the episode, a ehavior" Further review on, individual Behavior Support equire completion of data e target behaviors identified in on 7/9/19 the qualified es professional (QIDP) uld have documented the lient #4. PMENT	W 2	252	DEFICIENCY)		
	and teach clients to	rnish, maintain in good repair, use and to make informed use of dentures, eyeglasses,					

Facility ID: 921962

If continuation sheet Page 10 of 14

		AND HUMAN SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G044	B. WING			07/	09/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				05 EAST HEATH AVE SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 436	hearing and other c and other devices id interdisciplinary tea This STANDARD is	ommunications aids, braces, dentified by the m as needed by the client. s not met as evidenced by:	W 4	136			
W 441	Based on observat interview, the facility were purchased for Client #2 was not p recommended by th Review on 7/8/19 o dated 12/3/18 revea recommendation for During an interview intellectual disabiliti confirmed client #22 purchased as recor ophthalmologist. EVACUATION DRII CFR(s): 483.470(i)(The facility must ho varied conditions. This STANDARD is Based on review of the facility failed to were conducted at clients residing in th	tions, record review and y failed to ensure eyeglasses c client #2. The finding is: rovided with eyeglasses as ne ophthalmologist. f client #2's visual examination aled there was a or "new glasses". f on 7/9/19, the qualified es professional (QIDP) 's eyeglasses have not been mmended by the	W 4	441			

Facility ID: 921962

If continuation sheet Page 11 of 14

		AND HUMAN SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G044	B. WING			07/(09/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				05 EAST HEATH AVE MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 441	Continued From pa	ige 11	W 4	41			
	Review of fire drill re following:	eports on 7/8/19 revealed the					
	1am and 2am Furt	ird shift at the following times: her review revealed there Irills conducted on third shift h time period.					
W 460	intellectual disabiliti confirmed there we on third shift for the		W 4	60			
	Each client must re well-balanced diet in specially-prescribed	ncluding modified and					
	Based on observat interviews, the facili received a continuo consisting of neede identified in the indi	s not met as evidenced by: tions, record reviews and ity failed to ensure each client bus active treatment plan ed interventions and services ividual program plan (IPP) in his affected 2 of 3 audit clients ngs are:					
	1. Client #2's diet co	onsistency were not followed.					
	on 7/8/19, client #2 ham and cheese sa revealed client #2 p biting undetermined	servations at the day program was observed eating a whole andwich. Further observations bicking up the sandwich and d pieces and consuming them. nt #2 prompted to cut her					

If continuation sheet Page 12 of 14

		AND HUMAN SERVICES				FORM	07/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		34G044	B. WING			07/	09/2019
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HEATH A	VENUE HOME				105 EAST HEATH AVE SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 460	sandwich. Addition #2 did not cough wi b. During dinner of 7/8/19, client #2 wa beef which were lar was client #2 promp Additional observat cough while consur Review on 7/8/19 o revealed her food c Review on 7/9/19 o evaluation dated 5/2 consistency" Review on 7/9/19 o prevention guideling follow diet consisten physician" Review on 7/9/19 o dated 6/26/19 - 9/30 consistency is 1/2/1 During an interview intellectual disabiliti revealed client #2's in the correct diet c revealed staff shou cut her beef to to co 2. Client #5's diet c	al observations revealed client hile consuming her meal. oservations in the home on is observed eating pieces of rger than one inch. At no time pted to cut her beef. ions revealed client #2 did not ming her meal. f client #2's IPP dated 10/2/19 consistency is 1/2 - 1 inch. f client #2's nutritional 2/19 stated, "1/2 - 1 inch f client #2's choking es (on going) revealed, "Staff ncies as ordered by the f client #2's physician's orders 0/19 indicated her diet to 1 inch. f on 7/9/19, the qualified es professional (QIDP) sandwich should have been onsistency. Further interview Id have prompted client #2 to	W 2	460			

If continuation sheet Page 13 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 07/11/2019 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G044		B. WING			07/09/2019			
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
HEATH AVENUE HOME			SMITHFIELD, NC 27577					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 460	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 biting undetermined pieces and consuming them. At no time was client #5 prompted to cut her sandwich. Additional observations revealed client #5 did not cough while consuming her meal. Review on 7/8/19 of client #5's IPP dated 1/3/19 revealed her diet consistency is 1/2 to 1 inch. Review on 7/9/19 of client #5's meal guidelines stated, "Assist [Client #5] with fading assistance to cut her food into 1/2 to 1 inch pieces. Review on 7/9/19 of client #5's nutritional evaluation dated 9/25/18 revealed her diet consistency is 1/2 to 1 inch. During an interview on 7/9/19, the QIDP revealed client #5's sandwich should have been in the correct diet consistency.			460				

Facility ID: 921962

If continuation sheet Page 14 of 14