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O'BERRY NEURO-MEDICAL TREATMENT CENTER	400 OLD SMITHFIELD RD GOLDSBORO, NC 27530

(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 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 6 of 14 audit clients (#1, #2, #6, #8, #11, #13) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive dining equipment use, choice, program implementation, and mealtime guidelines. The findings are: 1. Client #8's mealtime guidelines were not implemented. During lunch observations in Building 277 on 8/26/19 at 12:12pm, client #8 consumed a whole slice of ham using his hands. Throughout the meal, the client was not prompted to place his hand in his lap. During lunch observations in Building 277 on 8/27/19 at 12:13pm, client #8 consumed a whole pork chop using his hands. Throughout the meal, the client consistently used both hands to hold his pork chop or placed his elbows on the table. Although Staff D sat beside him during the	W 249		

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

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W 249	Continued From page 1 majority of the meal, client #8 was not prompted to place his hand in his lap. Interview on 8/27/19 with Staff D indicated client #8's dining card notes he should be prompted to place his hand in his lap at meals. The staff also indicated client #8 does have a tendency to eat certain food items like pork chops with his hands. Review on 8/27/19 of client #8's IPP dated 3/15/19 revealed, "Although [Client #8] is an independent eater, he needs to be reminded how to appropriately eat his meals by getting him to put his left hand in his lap and giving him verbal reminders to slow down..." Additional review of the plan noted, "Staff should encourage [Client #8] to keep his hand in his lap (this keeps his fingers out of his food)." Interview on 8/27/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #8 should have prompted to place his hand in his lap as indicated in the IPP. 2. Client #11's choice to sleep in his own bed was not consistently offered. During morning observations on 8/27/19 in Building 364 at 6:15am, client #11 was curled up in the seat of a recliner chair. He was not in the reclined position but was in a small ball on the seat cushion sleeping. Interview on 8/27/19 at the time of the observation revealed that client #11 does not sleep in a bed. Staff A and Staff B both revealed that he never sleeps in his bed. Both staff stated he is always in a chair up front when they arrive at	W 249		

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W 249	Continued From page 2 11pm and when they move to the back, they move him to the back to sleep in that chair. Staff A and B in separate interviews stated the reason he does not sleep in his bed is due to him putting things like curtains or bedspreads down his throat. Staff B also said it is due to "PICA" and him needing to be with the staff at all times. Both staff also revealed that they do not offer client #11 a choice to sleep in his bed because he is not allowed to be in there alone. Staff B stated he has worked the shift before their shift to fill in and that shift does not offer him a choice to sleep in his bed either. Staff A stated in one interview, "This is his bedroom. We turn the light off and he sleeps right there every night." Review on 8/27/19 of client #11's IPP dated 11/12/19 revealed he has enhanced supervision/visual contact at all times. However, it stated that he should be given the choice to sleep in his bed or to sleep in a chair. There was also notations of him falling when in getting up from his chair on 4/3/19. Interview with the QIDP and the Home Life Support Assistant on 8/27/19 confirmed that all staff should offer client #11 a choice to sleep in his bed. It was also confirmed that when the staff move him from the front to the back and go right by his room, they should offer him an opportunity to sleep in his bed and sit by the door to supervise him. An interview on 8/27/19 with the psychologist revealed client #11's plan for PICA does not include him being restricted from sleeping in his bed and that the plan does include offering him a choice to sleep in his bed or a recliner.	W 249		

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3. Client #6 was not prompted to use her adaptive spoon during medication administration.

During afternoon medication administration observations in Building 501 on 8/26/19 at 3:56pm, client #6 was spoon fed her medications by a facility nurse. Further observations revealed the facility nurse used a plastic spoon. At no time was client #6 offered or prompted to use a spoon with a foam buildup.

During morning medication administration observations in Building 501 on 8/27/19 at 7:53am, the facility nurse handed client #6 a plastic spoon. Further observations revealed client #6 was not able to firmly grip the spoon and she let go of it. The facility nurse then proceeded to spoon feed client #6 her medications. At no time was client #6 offered or prompted to use a spoon with a foam buildup.

Review on 8/27/19 of client #6's ability to self medicate dated 4/23/19 stated, "Disposable spoon with foam buildup."

During an interview on 8/27/19, the facility nurse revealed client #6's adaptive spoon is used "when she appears to want to assist."

4. Client #1's mealtime guidelines and Occupational Therapy recommendations were not followed.

a. During lunch observations in Building 279 on 8/26/19 at 12:17pm, client #1 was seated at the

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table in her wheelchair with her feet resting on the leg rests of the wheelchair. She was eating her meal with one napkin tucked into the collar of her shirt and a portion of another napkin under her plate, with the two napkins overlapping in the middle. Her plate was positioned on the overlapping napkins. Throughout the meal, staff were holding a large green nosey cup with a flat base for client #1 to drink from. During the observation, client #1 was not using a non skid mat, foot stool or dining room chair. In addition, there was no observation of client #1 independently using or being prompted to use a large green nosey cup with flat base.

b. During dinner observations in Building 279 on 8/26/19 at 5:33pm, client #1 was seated at the table in her wheelchair with her feet resting on the leg rests of the wheelchair. Client #1's plate was positioned on a non-skid mat. Throughout the meal, staff were holding a large green nosey cup with a flat base for client #1 to drink from. During the observation, client #1 was not using a foot stool or dining room chair. In addition, there was no observation of client #1 independently using or being prompted to use a large green nosey cup with flat base.

c. During breakfast observations in Building 279 on 8/27/19 at 7:59am, client #1 was observed seated at the table in her wheelchair with her feet resting on the leg rests of the wheelchair. Client #1's plate was positioned on a non-skid mat. Throughout the meal, staff were observed to prompt client #1 to drink from her cup. She was observed to pick her cup up with staff assistance and drink from it. When prompted at other times, if having difficulty, staff would provide hand-over-hand assistance for client #1 to drink

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from her cup. During the observation, client #1 was not using a foot stool or dining room chair.

Review of client #1's IPP on 8/26/19 revealed that client #1 uses adaptive dining equipment and devices. A non skid mat is used to stabilize her high-sided three sectional plate; mealtime footstool to provide support for proper foot positioning during meals; and a large green nosey cup with flat base to promote independence.

Review of client #1's record on 8/27/19 revealed a OT evaluation dated 1/2/19. OT recommendations state that client #1 should sit upright in a dining room chair with her feet supported on the floor. Adaptive equipment should be used at each meal (plate, spoon, foot stool and non skid mat).

Interview with the QIDP on 8/27/19 revealed that the staff could have been using the napkins during lunch on 8/26/19 to catch food that was spilling and the non skid mat "may have been under the napkin." When asked why client #1 would be sitting in a wheelchair during meals instead of in a dining room chair using the foot stool, the QIDP revealed that the foot stool is available for use if needed. However, the QIDP stated that client #1's skills are regressing and staff use the wheelchair. The QIDP confirmed that the interdisciplinary team had not met to discuss this issue and that the OT's recommendations should be followed per the OT evaluation and IPP.

5. Client #2's behavior support plan (BSP) was not implemented.

a. During afternoon observations in Building 278

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W 249	Continued From page 6 on 8/26/19 from 3:26pm to 4:15pm, client #2 was observed trying to leave the activity area on multiple occasions. Each time she would try to leave the room, staff would block her by extending their arms and moving side to side. One staff was observed on several occasions to state "she just wants a hug" as client #2 was trying to get around her to leave the room. Throughout the observation, she was observed to be sucking her thumb. Review on 8/27/19 of client #2's BSP dated 7/1/19 reveals that she has a non target behaviors of "attempted departure," meaning she will attempt to leave a supervised area. The BSP states that client #2 should be provided with opportunities to walk and move around throughout her day both inside and outside of her home. In addition, if she wants to walk, she should be provided with the opportunity and space to do so. If it is time for an activity and she is restless or fidgety, she should be redirected to the task after allowing her to walk around for a few minutes. Interview with the QIDP on 8/27/19 revealed that staff should have allowed client #2 to walk, go to her room or to the bathroom and then return to the activity room. The QIDP confirmed that the BSP guidelines are currently what staff should be following. b. During observations in Building 278 on 8/26/19 from 4:15pm to 4:25pm, client #2 was observed in the dining room assisting with setting the table for dinner. Throughout the observation, client #2 was observed to suck her thumb. During observations in Building 278 on 8/27/19	W 249		

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W 249	Continued From page 7 from 9:30am to 9:51am, client #2 was observed on multiple occasions to be sitting in the activity room sucking her thumb. Further review of client #2's BSP dated 7/1/19 states that she will suck her thumb. If she does, staff should encourage her to remove her thumb from her mouth or by providing light physical prompt by touching her hand gently. Interview with the QIDP on 8/27/19 revealed that staff should have prompted client #2 to remove her hand from her mouth and of she didn't, provide her with the light physical prompts. 6. Client #13's behavior management strategies were not implemented. During observations in Building 278 on 8/27/19 from 9:30am to 9:51am, client #13 was observed sitting at the table and staff were repeatedly verbally prompting her to participate in a coloring activity and attempting to physically prompt her to color a picture with hand-over-hand assistance. During the observation, client #13 was observed on multiple occasions to hit herself in the chest. Review of client #13's IPP on 8/27/19 revealed that she will hit herself in her chest when she is upset or repeatedly encouraged to do something she does not want to do. Review of client #13's record on 8/27/19 revealed that she has a history of self-injurious behavior which is most often hitting herself in the chest. In the Annual Behavior Update dated 2/13/19, the person centered supports and suggested strategies state if client #13 starts to display SIB (which is hitting herself in the chest), staff should	W 249		

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W 249	Continued From page 8 verbally redirect her and gently prompt her hands away from her chest. If the agitation continues, programming should be discontinued until she calms. Interview with the QIDP on 8/27/19 revealed that these strategies are current and when she hits herself in the chest, client #13 should be redirected.	W 249		
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 interviews, the facility failed to ensure client #14's medication was administered in accordance with physician's orders. This affected 1 of 2 clients observed receiving medications in Building 276. The finding is: Client #14 was not administered his Florastor as ordered. During observations of medication administration in Building 276 on 8/26/19 at 3:50pm, client #14 received one packet of Florastor Kids mixed with applesauce. Review on 8/26/19 of client #14's physician's orders dated 8/15/19 revealed an order for Florastor, take one packet by mouth three times daily at 8am, 12n, and 4pm. The order noted, "Mix in any non-carbonated beverage."	W 368		

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W 368	Continued From page 9 Interview on 8/26/19 with the building's nurse confirmed the order was current; however, she usually administers the medication in applesauce because client #14 takes it better that way. Interview on 8/27/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the medication's physician's orders should have been followed as written.	W 368		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a clean and sanitary environment was maintained and the potential for cross-contamination was prevented. This potentially affected all clients residing in Building 276 and Building 278. The findings are: 1. Furniture was not kept clean and sanitary. During evening observations in Building 276 on 8/26/19 at 5:01pm, a client had a toileting accident while seating in a chair in the living room of the home. Staff C made other staff in the area aware of the client's toileting accident and indicated she needed to take him to the bathroom as his pants were wet with urine. Staff C then left the area with the client. After Staff C left, the chair used by the client remained in the living room area and was not cleaned or sanitized.	W 454		

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W 454	Continued From page 10 Interview on 8/26/19 with Staff C and Staff G revealed when toileting accidents happen on furniture in the home, the furniture should be cleaned immediately afterwards. Both staff indicated cleaning products were available in the home. Review on 8/27/19 of the facility's Infection Control Handbook (revised 6/6/11) under Sanitation of Residential and Non-Residential Areas revealed procedures to "Cleanse furniture, appliances, bed, tabletops, etc., every twenty-four (24) hours, more often if needed, with a germicidal solution...Continuously monitor all areas to assure the environment is clean at all times." Additional review of the Support Procedure Manual (revised 4/12/19) under Cleaning, Sanitizing and Disinfecting of the Group Home noted, "On a daily basis all living areas will be cleaned and sanitized by assigned staff while adhering to all applicable infection control and regulatory guidelines (OSHA, Sanitation, ICF/MR, and Nursing Facility) to ensure a clean and sanitary living area for each of the residents who reside at O' Berry Neuro-Medical Treatment Center)." Interview on 8/27/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the chair should have cleaned after the client's toileting accident. 2. Precautions were not taken to prevent possible cross-contamination for all residents in building 278. During afternoon observations in the home on 8/26/19 from 3:26pm to 4:25pm, client #2 was	W 454		

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W 454	Continued From page 11 observed to suck her thumb on multiple occasions. At 4:15pm, staff gave client #2 a stack of cloth napkins to take to the dining room. After putting the cloth napkins in a bin, client #2 washed her hands with staff assisting, and after drying her hands, immediately put her thumb back in her mouth. Client #2 assisted staff with scooping ice into a bin. Client #2 then assisted staff with setting up the dining room tables in preparation for supper time, including touching the cloth napkins, her peers adaptive dining equipment, forks, spoons, cups (at times with fingers inside the cups) and plates. In addition, throughout this process, client #2 was observed on multiple occasions sucking her thumb between touching these items. Review of client #2's record on 8/27/19 revealed a Behavior Support Plan dated 7/1/19. The BSP stated that client #2 sucks her thumb and that staff should encourage her to remove her thumb from her mouth or provide light physical prompts. Interview on 8/27/19 with the QIDP revealed that staff should have redirected client #2 from sucking her thumb and immediately wash her hands each time she did this prior to touching the dining equipment and utensils to prevent possible cross contamination.	W 454		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by:	W 488		

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W 488	Continued From page 12 Based on observation, record review and interview, the facility failed to ensure each client ate in a manner which was not stigmatizing. This affected 3 of 14 audit clients (#1, #10, #12). The finding is: 1. Clients were not assisted to eat in the least stigmatizing manner. a. During lunch observations in Building 277 on 8/26/19 at 12:08pm, client #12 consumed his meal with the upper portion of his napkin tucked into the collar of his shirt and the lower portion of the napkin positioned underneath his plate. The client consumed his food with his napkin positioned in this manner while Staff F sat next to him and assisted him at the meal. Interview on 8/27/19 with Staff F revealed she had positioned the napkin in this manner to prevent food from falling into client #12's lap. Additional interview indicated the staff had not been trained to position the client's napkin in this manner. Review on 8/27/19 of client #12's Individual Program Plan (IPP) dated 2/13/19 revealed the client requires staff assistance at meals. Additional review did not indicate napkins should be applied in the manner described for client #12 at meals. Interview on 8/27/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #12's napkin should not have been utilized in the manner described. b. During dinner observations in Building 276 on 8/26/19 at 5:30pm, client #10 consumed his meal	W 488		

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with one napkin tucked into the collar of his shirt and a portion of the other napkin positioned underneath his plate and the two napkins overlapping in the middle. Client #10 consumed his food with the two napkins positioned in this manner while Staff C assisted him during the meal. It should also be noted that only one small droplet of food was noted on the napkins at the end of the meal.

Interview on 8/27/19 with Staff C revealed the client's napkins had been positioned in this manner to "keep food from dropping on the floor...so all we have to do is take the napkin and dump it out."

Review on 8/27/19 of client #10's IPP dated 1/30/19 revealed, "Help [Client #10] eat as independently as possible while maintaining a safe and enjoyable mealtime." Additional review did not indicate napkins should be used in the manner described at meals.

Interview on 8/27/19 with the QIDP confirmed client #10 does not require his napkin to be applied in the manner described and staff "should not have done that."

c. During lunch observations in Building 279 on 8/26/19 at 12:10pm, client #1 was eating her meal with one napkin tucked into the collar of her shirt and a portion of another napkin under her plate, with the two napkins overlapping in the middle. Client #1 consumed her meal with the two napkins positioned this way. In addition, food was spilled onto the napkins. Staff was observed to pick the napkin up and put the food back in client #1's plate. Client #1 consumed the food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G004	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'BERRY NEURO-MEDICAL TREATMENT CENTER	400 OLD SMITHFIELD RD GOLDSBORO, NC 27530

(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 488	Continued From page 14 Review on 8/26/19 of client #1's IPP revealed that she utilizes a non-skid mat during dining to help prevent her plate from sliding while scooping and wears a clothing protector. Interview on 8/27/19 with staff H revealed that staff use the napkins this way "to catch the food and saliva that is falling." Interview on 8/27/19 with the QIDP revealed that staff "most likely do this to keep the area clean and spillage from getting on her clothing." The QIDP confirmed that because client #1's wears a clothing protector, this should not be done because if the clothing protector became dirty it could be changed out. In addition, the QIDP stated that the expectation is any food that has fallen onto the napkins, table, etc. should be discarded in the trash and never put back on a plate to be consumed.	W 488		