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

PRINTED: 09/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G009	B. WING				C 16/2019	
NAME OF F	PROVIDER OR SUPPLIER CREEK			5	TREET ADDRESS, CITY, STATE, ZIP CODE 709 US 70 EAST GOLDSBORO, NC 27534	1 03/	10/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMEN	TS	wo	000				
W 189	survey conducted of #NC00155822, NC		W 1	189				
	initial and continuin	rovide each employee with ng training that enables the rm his or her duties effectively, npetently.						
	Based on record refacility failed to ensitrained to documen	is not met as evidenced by: eview and interviews, the sure all staff were sufficiently nt required safety checks for 2 £1, #2). The findings are:						
	Safety checks were client #1 and client	e not properly documented for #2.						
	revealed, "Safety C The instructions no monitoring individu initially off under tir awake, S for sleep individuals with pul under the time and indicated at the bot must hand-off their another staff when be available to mon their safety check s and initial off under	of shift Safety Check Binders Check Monitoring Instructions". oted, "Staff are responsible for als every 30 minutes and mes. Staff will record A for and ON OFF or NA for those se oximeter in the column place their initials where atom of each time column. Staff a safety check sheets to they are on break or will not nitor. Supervisors will review sheets at the end of the shift and their shift and supervisors						
ABORATORY	I / DIRECTOR'S OR PROVII	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		I 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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34G009		B. WING		C				
NAME OF PROVIDER OR SUPPLIER] 3: ::::::0	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	/16/2019		
WALNUT CREEK			5709 US 70 EAST GOLDSBORO, NC 27534					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 189	Safety check monit reviewed by admini a. Additional review Individual Program physician's orders of Ox at bedtime while Ox settings: High S HR 185, Low HR 80 Further review of cl Check sheets for Administration.	binder at supervisors desk. oring forms will be periodically strative staff." on 9/16/18 of client #1's Plan (IPP) dated 9/20/18 and dated 5/30/19 indicated, "Pulse in bed and sleeping. Pulse ats 100% Low Sats 92% High 0". ient #1's 30-minutes Safety ugust 2019 and September following days with missing shift) sight system of the state of	W 1	89				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G009				C 09/16/2019	
NAME OF PROVIDER OR SUPPLIER WALNUT CREEK				5709	EET ADDRESS, CITY, STATE, ZIP CODE O US 70 EAST LDSBORO, NC 27534	1 03/	10/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189		ge 2 oted that various days/times er client #1's Pulse Oximeter	W 1	89			
	confirmed each saf filled in completely. indicated "NA" show use of his Pulse Ox Interview on 9/16/19 confirmed the 30 m	9 with the Shift Supervisor ety check sheet should be The Supervisor also ald not be noted for client #1's timeter. 9 with the Administrator inute safety check sheets ed without any missing					
	Individual Program physician's orders of Ox at bedtime while Ox settings: High S HR 185, Low HR 80 Further review of cl Check sheets for A	on 9/16/18 of client #2's Plan (IPP) dated 9/13/19 and dated 8/27/19 indicated, "Pulse in bed and sleeping. Pulse ats 100% Low Sats 92% High 0". ient #2's 30-minutes Safety ugust 2019 and September following days with missing					
	August 2019 (2nd s 7th - 12th = 2 day 13th - 18th = 3 da 19th - 24th = 3 da August 2019 (3rd s 1st - 6th = 6 days 7th - 12th = 5 days	ys ys hift)					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	34G009 B. WING			G			C 09/16/2019	
NAME OF PROVIDER OR SUPPLIER WALNUT CREEK				570	EET ADDRESS, CITY, STATE, ZIP CODE 9 US 70 EAST LDSBORO, NC 27534	1 001	16,2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE COMPLÉTION		
W 189	13th - 18th = 6 days 19th - 24th = 5 days 25th - 31st = 7 days 31st No document September 2019 (2 st - 15th = 8 days September 2019 (3 st - 15th = 14 days 1st - 15th = 14 days 1st - 15th = 14 days 1st - 15th = 16/18 (DON) confirmed expending the solution of the solution	ys ys ys ys ytation nd shift) s rd shift) ys. 9 with the Director of nursing ach safety check sheet should	W	189				