PRINTED: 08/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		- of the parties of the contract of the contra		TE SURVEY MPLETED
		34G004	B. WING			08/	27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	REATMENT CENTER		400	REET ADDRESS, CITY, STATE, ZIP CODE O OLD SMITHFIELD RD DLDSBORO, NC 27530	11112	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	3E	(X5) COMPLETION DATE
W 249	As soon as the interpretation formulated a client's each client must reconstruct treatment program interventions and seand frequency to su	2 (C. A. C. S. C.	W 24	49			
	Based on observation interviews, the facility audit clients (#1, #2 continuous active transported intervention the Individual Progradaptive dining equipments.	not met as evidenced by: ons, record reviews and ty failed to ensure 6 of 14 , #6, #8, #11, #13) received a eatment plan consisting of s and services as identified in am Plan (IPP) in the areas of ipment use, choice, program d mealtime guidelines. The			DHSR - Mental Health SEP 1 7 2019 Lic. & Cert. Section		
	1. Client #8's mealti implemented. During lunch observe 8/26/19 at 12:12pm	rations in Building 277 on client #8 consumed a whole		di in de pl	he Interdisciplinary Team will meet to iscuss client #8's Individual Program cluding mealtime strategies and etermine if any revisions are needed an of care.	Plan to the	09/13/2019
	meal, the client was hand in his lap. During lunch observe 8/27/19 at 12:13pm, pork chop using his the client consistent	rations in Building 277 on client #8 consumed a whole hands. Throughout the meal, ly used both hands to hold his his elbows on the table.		ok pr ac Re ID be	ccupational Therapy and QIDP will be serve and evaluate client #8's dining rogram and determine needed chang ddress appropriate dining skills. ecommendations will be shared with DT to confirm corrective measures that implemented to address client #8's realtime strategies.	es to	09/13/2019
AROPATORY		beside him during the	TUDE		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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G004	B. WING			08	/27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	REATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
W 249	to place his hand in Interview on 8/27/19 #8's dining card not place his hand in hi indicated client #8 cortain food items li Review on 8/27/19 3/15/19 revealed, "A independent eater, to appropriately eat put his left hand in him reminders to slow dithe plan noted, "State #8] to keep his hand fingers out of his food Interview on 8/27/19 Disabilities Professi	I, client #8 was not prompted his lap. If with Staff D indicated client es he should be prompted to a lap at meals. The staff also loes have a tendency to eat ke pork chops with his hands. If client #8's IPP dated although [Client #8] is an he needs to be reminded how his meals by getting him to his lap and giving him verbal lown" Additional review of ff should encourage [Client hin his lap (this keeps his bod)." If with the Qualified Intellectual conal (QIDP) confirmed client mpted to place his hand in his	W 2		Staff will be in-serviced on revisions mealtime strategies by the assigned clinician (i.e. Occupational Therapist Monitoring will occur on a daily basis QIDP, Floor Shift Nurse Supervisor, Consultant, and Unit Nurse Manage Monthly observations of mealtimes woccur by Occupational Therapy, Spe Language Pathologist, and Performal Improvement.	s by Unit r. vill	Ongoing Ongoing
	not consistently offer During morning obs Building 364 at 6:15 in the seat of a reclireclined position but seat cushion sleepir Interview on 8/27/19 observation revealed sleep in a bed. Staff that he never sleeps	ervations on 8/27/19 in am, client #11 was curled up her chair. He was not in the was in a small ball on the lig.			The Interdisciplinary Team will meet discuss client #11's Individual Progratincluding behavior plan for appropria of strategies, methods of providing client sleeping sites, and any additional recommendations. Staff will be in-serviced on plan of caclient #11 by the QIDP and Floor Shi Supervisors. Monitoring will occur on a nightly bast the Home Life Support Assistant. On basis the QIDP and Nursing Manage	am Plan teness noices re for ft is by a daily	09/26/2019 Ongoing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		34G004	B. WING _		08/2	27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL 1	REATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	11pm and when the move him to the ba A and B in separate he does not sleep it things like curtains throat. Staff B also him needing to be staff also revealed a choice to sleep in allowed to be in the has worked the shift that shift does not chis bed either. Staff "This is his bedroor sleeps right there e Review on 8/27/19 11/12/19 revealed by supervision/visual cit stated that he show sleep in his bed or also notations of hir from his chair on 4/1 Interview with the C Support Assistant of staff should offer clinis bed. It was also move him from the by his room, they sit to sleep in his bed a supervise him. An interview on 8/2 revealed client #11 include him being revenue.	ey move to the back, they ck to sleep in that chair. Staff interviews stated the reason in his bed is due to him putting or bedspreads down his said it is due to "PICA" and with the staff at all times. Both that they do not offer client #11 his bed because he is not be alone. Staff B stated he is the before their shift to fill in and offer him a choice to sleep in a A stated in one interview, in. We turn the light off and he wery night." of client #11's IPP dated the has enhanced contact at all times. However, and be given the choice to be sleep in a chair. There was in falling when in getting up 3/19. DIDP and the Home Life on 8/27/19 confirmed that all lient #11 a choice to sleep in confirmed that when the staff front to the back and go right hould offer him an opportunity and sit by the door to	W 249	will monitor through staff feedback a review with ongoing observations per facilitation schedule. The Unit Consultant and Unit Nurse Manager will facilitate on a weekly bath of the provide observations and correct feedback at least monthly and as need to be a served feedback at least monthly and	r asis. vement (ive	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY MPLETED
		34G004	B. WING		08	3/27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL 1	REATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP C 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULDBE	(X5) COMPLETION DATE
W 249	Continued From page 3 3. Client #6 was not prompted to use her adaptive spoon during medication administration.		W 24	Client #6 was scheduled and had from ICF/IID level of care to Solursing level of care on Septe 2019.	pecialized	09/03/2019
During afternoon medication administrations observations in Building 501 on 8/26/19 3:56pm, client #6 was spoon fed her medication by a facility nurse. Further observations the facility nurse used a plastic spoon, was client #6 offered or prompted to us		edication administration Iding 501 on 8/26/19 at as spoon fed her medications Further observations revealed		Occupational Therapist will ob evaluate client #6 and her ada equipment needs during medic administration in her current resetting.	ptive cation	09/03/2019
	was client #6 offere with a foam buildup During morning me observations in Buil	d or prompted to use a spoon dication administration ding 501 on 8/27/19 at		#6's current Interdisciplinary T strategies appropriate for her of	Recommendations will be shared with clien #6's current Interdisciplinary Team and strategies appropriate for her current residential setting will be reflected in her Nursing care plan.	
	7:53am, the facility nurse handed client #6 a plastic spoon. Further observations revealed client #6 was not able to firmly grip the spoon a she let go of it. The facility nurse then proceeds to spoon feed client #6 her medications. At no time was client #6 offered or prompted to use a spoon with a foam buildup.			The Interdisciplinary Team will review the use of adaptive equipment the appropriate equipment is being each of the clients.	ipment in at the	09/13/2019
	medicate dated 4/2 spoon with foam bu			GH 5-1 staff will be in-serviced recommendations and revision use of adaptive equipment dur medication administration by the Floor Shift Nurse Supervisor.	s regarding	09/27/2019
		on 8/27/19, the facility nurse adaptive spoon is used "when t to assist."		Monitoring will occur daily by the floor Shift Nurse Supervise		Ongoing
	not followed. a. During lunch obs	me guidelines and py recommendations were ervations in Building 279 on client #1 was seated at the		Weekly monitoring will occur be Consultant and Unit Nurse Ma Audits will be conducted by the Nursing, Assistant Director of Nerformance Improvement.	nager. Director of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G004	B. WING			08/	27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL	TREATMENT CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 100 OLD SMITHFIELD RD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSCIDENTIFYINGINFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	V 249 Continued From page 4 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		W 2		from ICF/IID level of care to Specialize Nursing level of care on September (2019.	zed 03,	09/03/2019
					Occupational Therapist and QIDP wi and evaluate client#1's mealtime and share recommendations with client # current Interdisciplinary Team to add the appropriate use of napkins, nose nonskid mat, foot stool and dining ch versus wheelchair.	d will 1's ress y cup,	09/03/2019
					Strategies appropriate for client #1's level of care will be reflected in her N care plan.		09/03/2019
	8/26/19 at 5:33pm, table in her wheelch leg rests of the whe	, client #1 was seated at the chair with her feet resting on the eelchair. Client #1's plate was			Monitoring will occur daily by the QID the Floor Shift Nurse Supervisor.	P and	Ongoing
	meal, staff were ho with a flat base for the observation, cli	on-skid mat. Throughout the olding a large green nosey cup or client #1 to drink from. During lient #1 was not using a foot			Weekly monitoring of all residents in will occur by the Unit Consultant, Uni Manager, and Performance Improver	t Nurse	Ongoing
	no observation of c	m chair. In addition, there was client #1 independently using or use a large green nosey cup			Monthly observations of all residents mealtimes will occur by Occupational Therapy, Speech Language Pathologand Performance Improvement.		Ongoing
	on 8/27/19 at 7:59a seated at the table resting on the leg re #1's plate was posi Throughout the me prompt client #1 to observed to pick he and drink from it. Wif having difficulty, s	t observations in Building 279 am, client #1 was observed in her wheelchair with her feet rests of the wheelchair. Client itioned on a non-skid mat. eal, staff were observed to drink from her cup. She was er cup up with staff assistance When prompted at other times, staff would provide esistance for client #1 to drink					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		34G004	B. WING			08	/27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	REATMENT CENTER		40	TREET ADDRESS, CITY, STATE, ZIP CODE 00 OLD SMITHFIELD RD OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	from her cup. Durin was not using a food. Review of client #1' client #1 uses adapted devices. A non skid high-sided three set footstool to provide positioning during in cup with flat base to the recommendations of the recommendations of the staff could be used at each of the staff could have during lunch on 8/20 spilling and the non under the napkin." Would be sitting in a instead of in a dining stool, the QIDP reveauallable for use if it staff use the wheeled that the interdiscipling discuss this issue a recommendations of the property of the property is sevaluation and IPP. 5. Client #2's behave not implemented.	g the observation, client #1 It stool or dining room chair. It stool of stool is stool is stool is needed. However, the QIDP is skills are regressing and chair. The QIDP confirmed mary team had not met to not did that the OT's hould be followed per the OT.	W 2	T cci iii cc a t	The Interdisciplinary Team will meet discuss client #2's Individual Program neluding behavior plan for appropriate of strategies, methods for addressing attempted departures and redirection humb sucking, and any additional recommendations.	n Plan teness	09/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G004	B. WING _		08	/27/2019	
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL	TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
W 249	on 8/26/19 from 3:3 observed trying to multiple occasions leave the room, sta	26pm to 4:15pm, client #2 was leave the activity area on . Each time she would try to aff would block her by	W 24	Staff will be in-serviced on revision of care for client #2 by the assigned clinician (i.e. Psychologist). Monitoring will occur on a nightly be the Home Life Support Assistant.	d asis by	09/18/2019 Ongoing	
	One staff was obsestate "she just wan trying to get around	ns and moving side to side. erved on several occasions to ts a hug" as client #2 was d her to leave the room. servation, she was observed to		basis the QIDP and Nursing Manag will monitor through staff feedback review with ongoing observations p facilitation schedule.	and data er		
Review on 8/27/1 7/1/19 reveals that		of client #2's BSP dated she has a non target		The Unit Consultant and Unit Nurse Manager and Performance Improve will facilitate on a weekly basis.		Ongoing	
	will attempt to leave states that client #2 opportunities to wa throughout her day home. In addition, i should be provided space to do so. If it is restless or fidget	apted departure," meaning she is a supervised area. The BSP is should be provided with lk and move around both inside and outside of her if she wants to walk, she with the opportunity and is time for an activity and she y, she should be redirected to ling her to walk around for a		Psychology will provide observation corrective feedback at least monthly needed.		Ongoing	
	staff should have a her room or to the t the activity room. T	QIDP on 8/27/19 revealed that llowed client #2 to walk, go to pathroom and then return to he QIDP confirmed that the currently what staff should be					
	from 4:15pm to 4:29 in the dining room a	ons in Building 278 on 8/26/19 5pm, client #2 was observed assisting with setting the table out the observation, client #2 ck her thumb.					
	During observations	s in Building 278 on 8/27/19					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		34G004	B. WING _		08/27/2019	
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	REATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
W 249	on multiple occasion room sucking her the Further review of cli states that she will staff should encoura from her mouth or be prompt by touching	fram, client #2 was observed in the activity numb. Sent #2's BSP dated 7/1/19 is suck her thumb. If she does, age her to remove her thumb by providing light physical her hand gently.	W 24	9		
	staff should have pr her hand from her m	IDP on 8/27/19 revealed that ompted client #2 to remove nouth and of she didn't, light physical prompts.				
	During observations from 9:30am to 9:51 sitting at the table at	vior management strategies ed. s in Building 278 on 8/27/19 am, client #13 was observed nd staff were repeatedly her to participate in a coloring		Client #13 was scheduled and has m from ICF/IID level of care to Specializ Nursing level of care on September 0 2019. The Interdisciplinary Team will meet the discuss client #13's Individual Program.	red 13, 20 09/03/2019	
	activity and attempti color a picture with I During the observati	ng to physically prompt her to nand-over-hand assistance. ion, client #13 was observed as to hit herself in the chest.		including behavior plan for redirecting injurious behaviors, and appropriate programmatic activities for engaging #13, and any additional recommenda	client	
	that she will hit herse	I's IPP on 8/27/19 revealed elf in her chest when she is encouraged to do something to do.		Strategies appropriate for client #13's current level of care will be reflected i Nursing care plan.	n her	
	that she has a histor which is most often the Annual Behavior person centered sup	's record on 8/27/19 revealed by of self-injurious behavior hitting herself in the chest. In Update dated 2/13/19, the oports and suggested		Monitoring will occur daily by the QID the Floor Shift Nurse Supervisor. Weekly monitoring will occur by the U Consultant, Unit Nurse Manager, and Performance Improvement.	nit Ongoing	
		ent #13 starts to display SIB self in the chest), staff should	48.6	Psychology will provide observations	and Ongoing	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		34G004	B. WING _		08/	/27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	FREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	verbally redirect her away from her ches programming shoul calms. Interview with the Cothese strategies are	age 8 or and gently prompt her hands st. If the agitation continues, lid be discontinued until she QIDP on 8/27/19 revealed that the current and when she hits the client #13 should be	W 24	g corrective feedback at least monthly needed.	and as	
W 368	DRUGADMINISTR CFR(s): 483.460(k) The system for drug	g administration must assure dministered in compliance with	W 368	The Medical Provider will review clier #14's current medication administration order and complete an order clarifical	on tion to	08/27/2019
	This STANDARD is Based on observation interviews, the facilion medication was admonths orders.	s not met as evidenced by: ion, record review and ity failed to ensure client #14's ministered in accordance with This affected 1 of 2 clients medications in Building 276.		ensure consistency and to address cl #14's needs. Client #14's MAR will be updated as the task analysis. Nursing Staff will be in-serviced on cl #14's plan of care and any recommer revisions by the assigned clinician.	well as	08/27/2019 09/13/2019
	ordered. During observations in Building 276 on 8 received one packe	administered his Florastor as s of medication administration 8/26/19 at 3:50pm, client #14 et of Florastor Kids mixed with		The Interdisciplinary Team will meet the discuss client #14's Individual Progration including medication administration strategies, physician's orders for mediadministration, and any additional recommendations.	m Plan	
	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."			At bimonthly Medication Habilitation meetings, all client's medication administration information will be reviby the involved Interdisciplinary Teammembers and updated accordingly.	ewed	Ongoing

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		E CONSTRUCTION		TE SURVEY MPLETED
		34G004	B. WING			08/	27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	REATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
W 368		tl		Monitoring will occur daily by the QIDP and the Floor Shift Nurse Supervisor.		Ongoing	
	confirmed the order usually administers	9 with the building's nurse was current; however, she the medication in applesauce			Weekly monitoring will occur by the L Consultant and Unit Nurse Manager.		Ongoing
W 454	Interview on 8/27/19 Disabilities Professi medication's physic followed as written.		W 45	F	Audits of Medication Administration vonducted by the Director of Nursing Assistant Director of Nursing, and Performance Improvement.		Ongoing
		ovide a sanitary environment d transmission of infections.					
	Based on observation interviews, the facility sanitary environmer potential for cross-control This potentially affects.	not met as evidenced by: ons, record reviews and ty failed to ensure a clean and nt was maintained and the ontamination was prevented. cted all clients residing in uilding 278. The findings are:					
	During evening obset 8/26/19 at 5:01pm, a accident while seatil of the home. Staff C	ervations in Building 276 on a client had a toileting ng in a chair in the living room ande other staff in the area		re d fu a	The Interdisciplinary Team will meet to eview the incident in GH 276 and letermine corrective action to prevenuture incidents (i.e. cleaning toileting accidents immediately) to prevent crospontamination.	t	09/09/2019
	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.			ir	Recommendations will be shared with the form of an in-service training by assigned clinician (Infection Control N	the	09/27/2019
					Monitoring will occur daily by the QID floor Shift Nurse Supervisor, Unit Nu		Ongoing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION		TE SURVEY MPLETED
		34G004	B. WING			08/	27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	REATMENT CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 00 OLD SMITHFIELD RD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 454	revealed when toile furniture in the hom cleaned immediated	ge 10 9 with Staff C and Staff G ting accidents happen on e, the furniture should be y afterwards. Both staff products were available in the	W 4		Manager, Unit Consultant, and Environmental Services staff. Sanitation Inspects will be conducted Performance Improvement, Infection Control Nurse, and Safety Officer per schedule.		Ongoing
	Control Handbook (Sanitation of Reside Areas revealed prograppliances, bed, tal (24) hours, more of germicidal solution. areas to assure the times." Additional reprocedure Manual (Cleaning, Sanitizing Home noted, "On a be cleaned and san adhering to all appli regulatory guideline and Nursing Facility sanitary living area.	of the facility's Infection revised 6/6/11) under ential and Non-Residential cedures to "Cleanse furniture, pletops, etc., every twenty-four ten if needed, with aContinuously monitor all environment is clean at all eview of the Support (revised 4/12/19) under and Disinfecting of the Group daily basis all living areas will itized by assigned staff while cable infection control and s (OSHA, Sanitation, ICF/MR, etc.) to ensure a clean and for each of the residents who euro-Medical Treatment					
	Disabilities Professi	with the Qualified Intellectual onal (QIDP) confirmed the leaned after the client's					
		not taken to prevent possible for all residents in building		r f	The Interdisciplinary Team will meet to review the incident in GH 278 and determine corrective action to preven future occurrence (i.e. thumb sucking assisting with meal set-up) of cross	t	09/09/2019
		servations in the home on n to 4:25pm, client #2 was			contamination.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G004	B. WING		08/	/27/2019
	PROVIDER OR SUPPLIER Y NEURO-MEDICAL T	TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
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		W 454	Recommendations will be shared with in the form of an in-service training be assigned clinician (Infection Control Monitoring will occur daily by the QIE Floor Shift Nurse Supervisor, Unit Nu	by the Nurse). DP,	
	drying her hands, ir back in her mouth. scooping ice into a staff with setting up preparation for supplied the cloth napkins, hequipment, forks, sfingers inside the cuthroughout this product.	mmediately put her thumb Client #2 assisted staff with bin. Client #2 then assisted the dining room tables in per time, including touching her peers adaptive dining spoons, cups (at times with ups) and plates. In addition, cess, client #2 was observed the spoons are thumb		Manager, Unit Consultant, and Environmental Services staff. Sanitation Inspects will be conducted Performance Improvement, Infection Control Nurse, and Safety Officer peschedule.	1	Ongoing
	a Behavior Support stated that client #2 staff should encours	's record on 8/27/19 revealed t Plan dated 7/1/19. The BSP 2 sucks her thumb and that rage her to remove her thumb provide light physical prompts.				
W 488	staff should have re sucking her thumb a hands each time sh dining equipment ar cross contamination	ND SERVICE	W 488	3		
		ssure that each client eats in a with his or her developmental			n	
	This STANDARD is	s not met as evidenced by:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G004	B. WING			08/27/2019	
NAME OF PROVIDER OR SUPPLIER O'BERRY NEURO-MEDICAL TREATMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	PREFIX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE
W 488	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 theleast stigmatizing manner. a. During lunch observations in Building 277 on		W 4	discuss client #12's Individual P including appropriate napkin usa determine if any revisions are neplan of care.	The Interdisciplinary Team will meet discuss client #12's Individual Progra including appropriate napkin usage a determine if any revisions are neede plan of care. Occupational Therapy and QIDP will	am Plan and d to the	
					observe and evaluate client #12's dining or ogram and determine needed changes to address dining skills including appropriate papkin usage.		03/23/2013
	meal with the upper into the collar of his the napkin positione client consumed his positioned in this m	26/19 at 12:08pm, client #12 consumed his eal with the upper portion of his napkin tucked to the collar of his shirt and the lower portion of e napkin positioned underneath his plate. The ient consumed his food with his napkin ositioned in this manner while Staff F sat next to m and assisted him at the meal.		12000	Recommendations will be shared with the DT to confirm corrective measures that will be implemented to address client #12's nealtime strategies are occurring in a manner consistent with his developmental evel.		09/27/2019
	had positioned the prevent food from fa Additional interview	9 with Staff F revealed she napkin in this manner to alling into client #12's lap. indicated the staff had not ition the client's napkin in this			Staff will be in-serviced on appropriation of the napkin by the assigned clinicia (QIDP and Floor Shift Nurse Supervious) Monitoring will occur on a daily basis	n sor).	Ongoing Ongoing
	manner.				QIDP, Floor Shift Nurse Supervisor, Unit Consultant, and Unit Nurse Manager.		
	Program Plan (IPP) client requires staff Additional review di	ew on 8/27/19 of client #12's Individual ram Plan (IPP) dated 2/13/19 revealed the requires staff assistance at meals. ional review did not indicate napkins should uplied in the manner described for client #12		1	Monthly observations of mealtimes woccur by Occupational Therapy, Spelanguage Pathologist, and Performal	ech nce	Ongoing
	at meals. Interview on 8/27/19 Disabilities Professi #12's napkin should	9 with the Qualified Intellectual onal (QIDP) confirmed client I not have been utilized in the					Ongoing
		servations in Building 276 on client #10 consumed his meal			The Interdisciplinary Team will meet discuss client #10's Individual Progra		09/09/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G004	B. WING _		08/	27/2019	
NAME OF PROVIDER OR SUPPLIER O'BERRY NEURO-MEDICAL TREATMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 400 OLD SMITHFIELD RD GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
W 488	with one napkin tuctor and a portion of the underneath his plat overlapping in the rhis food with the two manner while Staff meal. It should also droplet of food was end of the meal. Interview on 8/27/11 client's napkins had manner to "keep for floorso all we have dump it out." Review on 8/27/19 1/30/19 revealed, "lindependently as posafe and enjoyable did not indicate napmanner described at Interview on 8/27/11 client #10 does not applied in the manner have done that. c. During lunch obs 8/26/19 at 12:10pm meal with one napk shirt and a portion of plate, with the two middle. Client #1 control two napkins position was spilled onto the to pick the napkin under the staff of the sta	ekked into the collar of his shirt other napkin positioned e and the two napkins middle. Client #10 consumed o napkins positioned in this C assisted him during the be noted that only one small noted on the napkins at the 9 with Staff C revealed the been positioned in this od from dropping on the e to do is take the napkin and of client #10's IPP dated Help [Client #10] eat as possible while maintaining a mealtime." Additional review which should be used in the at meals.	W 48	including appropriate napkin usage determine if any revisions are need plan of care. Occupational Therapy and QIDP wobserve and evaluate client #10's coprogram and determine needed chaddress dining skills including approaphinapkin usage. Recommendations will be shared wordered be implemented to address client # mealtime strategies are occurring in manner consistent with his develop level. Staff will be in-serviced on appropriof the napkin by the assigned clinic (QIDP and Floor Shift Nurse Supervisor Consultant, and Unit Nurse Manage Monthly observations of mealtimes occur by Occupational Therapy, Sp Language Pathologist, and Perform Improvement. Client #1 was scheduled and has man from ICF/IID level of care to Special Nursing level of care on September 2019. Occupational Therapy and QIDP with observe and evaluate client #1's dir program including appropriate napkers.	led to the ill sining anges to opriate vith the that will 10's a mental ate use ian visor). is by Unit er. will eech lance lized 103,	09/23/2019 09/27/2019 Ongoing Ongoing 09/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G004	B. WING			08/27/2019	
NAME OF PROVIDER OR SUPPLIER O'BERRY NEURO-MEDICAL TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 488	Review on 8/26/19 she utilizes a non-s prevent her plate fr wears a clothing pro- Interview on 8/27/1	of client #1's IPP revealed that kid mat during dining to help om sliding while scooping and otector. 9 with staff H revealed that is this way "to catch the food	W 4		and will share recommendations with #1's current NF Interdisciplinary Tea address the appropriate use of napk Strategies appropriate for client #1's level of care will be reflected in her No care plan. Monitoring will occur daily by the QIE Floor Shift Nurse Supervisor, Unit Consultant, and Unit Nurse Manager	m to ins. current lursing DP,	09/03/2019 Ongoing
	staff "most likely do and spillage from g QIDP confirmed that clothing protector, the because if the cloth could be changed of stated that the expension	9 with the QIDP revealed that this to keep the area clean etting on her clothing." The at because client #1's wears a his should not be done ing protector became dirty it but. In addition, the QIDP ectation is any food that has kins, table, etc. should be sh and never put back on a ed.			Monthly observations of mealtimes woccur by Occupational Therapy, Spe Language Pathologist, and Performa Improvement.	ech	Ongoing



ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

KODY KINSLEY • Deputy Secretary for Behavioral Health & IDD

HELEN WOLSTENHOLME • DSOHF Director

MICHAEL BUNCH, MD • Acting Director

September 09, 2019

Lesa Williams. MSW, QIDP NC Division of Health Service Regulation Mental Health Licensure and Certification Section 2718 Mail Service Center Raleigh, North Carolina 27699-2718

RE: Plan of Correction for ICF/IID

Dear Ms. Williams:

Attached is a copy of O'Berry Neuro-Medical Treatment Center Plan of Correction for the deficiency cited during the survey conducted on August 26, 2019 through August 27, 2019. Corrective and follow-up action for the deficiency will be completed by October 26, 2019.

Please do not hesitate to call me if you have any questions or concerns about the plan of correction. I can be reached at (919) 581-4013 or by electronic mail at lisa.ruggery@dhhs.nc.gov.

Sincerely,

Lisa B. Ruggery

Deputy Director - Standards Management

LBR/

Attachment

DHSR - Mental Health

SEP 1 7 2019

Lic. & Cert. Section