

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

PRINTED: 12/19/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/13/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>WALNUT CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5709 US 70 EAST</b> <b>GOLDSBORO, NC 27534</b>		
(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 339	<p><b>NURSING SERVICES</b> CFR(s): 483.460(c)(4)</p> <p>Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to provide nursing services in the areas of assessment, monitoring, documentation, and communication with the facility physician. This affected 1 of 3 deceased clients (#1) in the group home. The finding is:</p> <p>Client #1 did not receive nursing care after a visit to the emergency room.</p> <p>Record review on 12/12/19 revealed client#1 was treated in the emergency room on 6/27/19 for shortness of breath with a primary diagnosis of congestion of upper respiratory and returned to the group home the same day. Client #1's chart did not reveal any documentation indicating the facility's nurse had assessed any vital signs a upon return. Further review revealed the facility's nurse contact the physician on 6/2/19 regarding unstable condition of the client. The order was given to assess vital signs every 2 hours for 24 hours. The records indicated only blood pressure was assessed every two hours.</p> <p>Record review on 12/12/19 revealed client #1 was admitted to emergency room on 6/29/19 due to, "unresponsiveness ...and hypoxia and intubated.... he was admitted to ICU for further evaluation...he was febrile to as high as 103 degrees."</p>	W 339			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 339	Continued From page 1  Interview on 12/12/19 with a the facility nurse that was on duty on 6/28/19 (via phone) revealed the physician gave her a verbal order of blood pressure only and added she might have wrote with an error for vital sign. The facility nurse did not perform the full vital sign and reported to the oncoming nurse that the order was given for blood pressure only.  Interview on 12/12/19 with the director of nursing (DON) revealed the facility nurse did not follow the pycsian order as given or the documented the order with an error .	W 339		