DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G329	B. WING			R / 30/2020		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
KIMBERLY ROAD			1503 KIMBERLY ROAD NEW BERN, NC 28562					
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
W 000	INITIAL COMMENTS		W 00	00				
W 154	previous deficiencie previous deficiencie two new areas of ne facility remains out STAFF TREATMEN CFR(s): 483.420(d)	IT OF CLIENTS (3) ive evidence that all alleged	W 1	54				
	This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure an injury of unknown origin involving client #5 was thoroughly investigated. This affected 1 of 2 audit clients. The finding is:							
	A fracture to client #5's left foot was not thoroughly investigated.							
	client #5 was seate	home on 1/30/20 at 6:40am, d in his wheelchair in his eg/foot was in an air splint or						
	revealed client #5 h knows how it happen may have happene his bed or while cra the home. Addition	20 with Staff A, B and C has a fractured foot and no one ened. The staff indicated it d when he transferred out of wling around on the floor in al interview indicated his foot ollen one morning when he						
	Review on 1/30/20	of client #5's physician's						

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

TITLE

(X6) DATE

PRINTED: 01/31/2020

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES	0	FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MU	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
34G329 B. WING	S	R 01/30/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE		
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	IX (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
W 154 Continued From page 1 notes/orders dated 1/16/20 revealed, "Left foot/leg swellingdistal fibula fracture LLEair splint to remain on" W Review on 1/30/20 of a facility investigation dated 1/21/20 revealed, "On January 15, 2020, [Staff A] was bathing [Client #5] and she noticed that his left ankle was slightly red. [Client #5] did not seem to be in pain and was monitored until he went to bed. On January 16, 2020, [Client #5] was assisted in getting out of bed. [Staff A] noticed that [Client #5's] ankle was swollen. She immediately notified [Residential Manager] at 6:30am." Additional review of five staff statements included in the investigation indicated the following regarding the injury to client #5's left foot: - "could have been from him getting transferred in and out of the chair, scooting around on the floor or while he is having his out of wheelchair time." • "He transfers himself on and off the furniture and gets in and out of the bed at night independently. [Client #5] has to be closely monitored during the night because in the past, his foot has gotten stuck in the bedrails when attempting to get out of the bed but there were not injuries." Further review of the investigation concluded that client #5 is active, can move around in his wheelchair using his legs, and can transfer to the floor and back into the chair. "He could have	154		

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If continuation sheet Page 2 of 5

		AND HUMAN SERVICES				FORM	01/31/2020 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G329	B. WING			R 01/30/2020			
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W 154	task." Recommend all staff on reporting reporting Level I inju Continued review of indicate any intervie staff working during occurred. Although home is interviewat interviewed. Interviewed of any for may have occurred interviewed by any fracture. The staff to write statements. Interview on 1/30/20 Disabilities Professi not conducted the in acknowledged that have been beneficia client #5's foot injur STAFF TREATMEN CFR(s): 483.420(d)	when doing either of these dations included inservices for g timelines and one staff on uries. If the investigation did not ews had been conducted with g the time the injury could have n at least one client in the ole, the client had not been 20 with Staff B and C (who on the day in which the injury) revealed they had not been one regarding client #5's noted they had only been told 0 with the Qualified Intellectual ional (QIDP) indicated she had nvestigation; however, she formal staff interviews could al in determining the cause of y. NT OF CLIENTS)(4)	W 1		DEFICIENCY)				
	corrective action mu This STANDARD is Based on observat interviews, the facili corrective action wa potential reoccurrer	on is verified, appropriate ust be taken. s not met as evidenced by: tions, record review and ity failed to ensure appropriate as taken to prevent the nce of an injury involving client of 2 audit clients. The finding							

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES			FORM	01/31/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 157	Continued From pa is:	ige 3	W 157			
	Appropriate correct after an injury to clie	tive action was not taken to ent #5's left foot.				
	client #5 was seate	home on 1/30/20 at 6:40am, ed in his wheelchair in his eg/foot was in an air splint or				
	revealed client #5 h knows what happer have happened who bed or while crawlir home. Additional ir	20 with Staff A, B and C has a fractured foot and no one ned. The staff indicated it may en he transferred out of his ng around on the floor in the nterview indicated his foot was n one morning when he woke				
	notes/orders dated	of client #5's physician's 1/16/20 revealed, "Left istal fibula fracture LLEair "				
	1/21/20 revealed, "o was bathing [Client left ankle was slight seem to be in pain went to bed. On Ja was assisted in get noticed that [Client	of a facility investigation dated On January 15, 2020, [Staff A] #5] and she noticed that his tly red. [Client #5] did not and was monitored until he anuary 16, 2020, [Client #5] ting out of bed. [Staff A] #5's] ankle was swollen. She d [Residential Manager's				
	in the investigation	f five staff statements included indicated the following to client #5's left foot:				

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		AND HUMAN SERVICES				FORM	01/31/2020 APPROVED 0938-0391
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W 157			W 1	157			

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