STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	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) 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 000	INITIAL COMMENTS A revisit was conducted on 1/30/20 for all previous deficiencies cited on 11/19/19. All previous deficiencies were corrected; however, two new areas of noncompliance were found. The facility remains out of compliance.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. 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. Upon arrival to the home on 1/30/20 at 6:40am, client #5 was seated in his wheelchair in his bedroom. His left leg/foot was in an air splint or boot. Interviews on 1/30/20 with Staff A, B and C revealed client #5 has a fractured foot and no one knows how it happened. The staff indicated it may have happened when he transferred out of his bed or while crawling around on the floor in the home. Additional interview indicated his foot was noted to be swollen one morning when he woke up. Review on 1/30/20 of client #5's physician's	W 154		

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

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W 154	Continued From page 1	W 154		

notes/orders dated 1/16/20 revealed, "Left foot/leg swelling...distal fibula fracture LLE...air splint to remain on..."

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."

- "...maybe he could of hit his foot while he was on the floor scooting around."

- "...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

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W 154	Continued From page 2 fractured his ankle when doing either of these task." Recommendations included inservices for all staff on reporting timelines and one staff on reporting Level I injuries. Continued review of the investigation did not indicate any interviews had been conducted with staff working during the time the injury could have occurred. Although at least one client in the home is interviewable, the client had not been interviewed. Interviews on 1/30/20 with Staff B and C (who were both working on the day in which the injury may have occurred) revealed they had not been interviewed by anyone regarding client #5's fracture. The staff noted they had only been told to write statements. Interview on 1/30/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she had not conducted the investigation; however, she acknowledged that formal staff interviews could have been beneficial in determining the cause of client #5's foot injury.	W 154		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure appropriate corrective action was taken to prevent the potential reoccurrence of an injury involving client #5. This affected 1 of 2 audit clients. The finding	W 157		

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W 157	Continued From page 3 is: Appropriate corrective action was not taken to after an injury to client #5's left foot. Upon arrival to the home on 1/30/20 at 6:40am, client #5 was seated in his wheelchair in his bedroom. His left leg/foot was in an air splint or boot. Interviews on 1/30/20 with Staff A, B and C revealed client #5 has a fractured foot and no one knows what happened. The staff indicated it may have happened when he transferred out of his bed or while crawling around on the floor in the home. Additional interview indicated his foot was noted to be swollen one morning when he woke up. Review on 1/30/20 of client #5's physician's notes/orders dated 1/16/20 revealed, "Left foot/leg swelling...distal fibula fracture LLE...air splint to remain on..." 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's name] 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:	W 157		

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W 157	Continued From page 4 - "...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." - "...maybe he could of hit his foot while he was on the floor scooting around." - "...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 fractured his ankle when doing either of these task." Recommendations included inservices for all staff on reporting timelines and one staff on reporting Level I injuries. The recommendations did not include any corrective actions to be taken to prevent reoccurrence of the injury to client #5. Interview on 1/30/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she had not conducted the investigation; however, no corrective actions had been taken to prevent the potential for future injury to client #5.	W 157		