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

PRINTED: 01/31/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	I (VO) MULTI	OMB MC	MB NO. 0938-039		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		ATE SURVEY OMPLETED	
		B. WING _	01	R 01/30/2020			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1503 KIMBERLY ROAD NEW BERN, NC 28562		1700/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDBE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	rs	W 000			- Community of the Comm	
	previous deficiencie previous deficiencie two new areas of no facility remains out of STAFF TREATMEN CFR(s): 483.420(d). The facility must haviolations are thorous. This STANDARD is Based on observation interviews, the facility unknown origin involutions are thorous investigated. This after the finding is: A fracture to client #8 thoroughly investigated. Upon arrival to the hoclient #5 was seated bedroom. His left leg boot. Interviews on 1/30/20 revealed client #5 has knows how it happendars bed or while craw the home. Additional was noted to be swolwoke up.	or cord review and y failed to ensure an injury of ving client #5 was thoroughly fected 1 of 2 audit clients.	W 154	Anytime an injury occurs of un origin the Residential Team Le notify the Director of Program and it will be investigated thore staff involved will be interview questions that are developed by and then provide a written state resident that can provide inform be interviewed and provide a staff regarding reporting timelin Protocols will be put in place, wassistance of a Physical Therapia assist with keeping client #5 fre injury. This will be completed 130, 2020. Responsible person: Team Lead DHSR - Mental He FEB 18 2020 Lic. & Cert. Sect	operations oughly. All yed with the Team ment. Any nation will attement. I for all less. with the st, to e from by March er		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERREPRESENTATIVE'S SIGNATURE

(X6) DATE

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STATEMENT OF DEFICIENCIES		T OF DEFICIENCIES	(V4) BBOMBERIOUS INTERIOR					7 VID 140. 0936-039	
AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
				A. BUILDING		3			
34G329		34G329	B. WING			R 01/30/2020			
I	NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	73072020	
	KIMBER	LY ROAD			1	1503 KIMBERLY ROAD NEW BERN, NC 28562			
	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10					
	PRÉFIX TAG			PREF	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		DBE	COMPLETION DATE	
	W 154	Continued From pag	no 1	101	154				
		mada i rom pa		W	154				
fo		notes/orders dated 1/16/20 revealed, "Left foot/leg swellingdistal fibula fracture LLEair splint to remain on"							
		Review on 1/30/20 o	of a facility investigation dated						
	The state of the s	1/21/20 revealed, "O	on January 15, 2020, [Staff A]						
		was bathing [Client a	#5] and she noticed that his ly red. [Client #5] did not						
		seem to be in pain a	nd was monitored until he						-
		went to bed. On Jan	uary 16, 2020, [Client #5]						
	THE PARTY OF THE P	noticed that [Client #	ng out of bed. [Staff A] 5's] ankle was swollen. She						
		immediately notified	[Residential Manager] at						
	411	6:30am."	five staff statements included		9 M	Intentionally Left Blank			
							1		
		regarding the injury t	ndicated the following o client #5's left foot:				10 mm		
		- "could have bee	n from him getting				de la company		
		transferred in and ou	t of the chair, scooting				The state of the s		
		around on the floor of wheelchair time."	r while he is having his out of						
					ĺ		-		
		 "maybe he could on the floor scooting 	of hit his foot while he was around."				ere establishmen out o		
	-	- "He transfers him	self on and off the furniture		1				
	-	and gets in and out o	f the bed at night						
			t #5] has to be closely night because in the past,						
			uck in the bedrails when		-				
	a	attempting to get out	of the bed but there were		the characteristics of				
	r	not injuries."							
			investigation concluded that		4				
			n move around in his		STATE OF THE PARTY				
			egs, and can transfer to the chair. "He could have						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		240220			R	
34G329			B. WING		01/3	30/2020
NAME OF PROVIDER OR SUPPLIER KIMBERLY ROAD				STREET ADDRESS, CITY, STATE, ZIP CODE 1503 KIMBERLY ROAD NEW BERN, NC 28562		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 154	fractured his ankle of task." Recommenda all staff on reporting reporting Level I injute Continued review or indicate any interview staff working during occurred. Although home is interviewab interviewed. Interviews on 1/30/2 were both working of may have occurred) interviewed by anyofracture. The staff not to write statements. Interview on 1/30/20 Disabilities Profession to conducted the inacknowledged that if have been beneficial client #5's foot injury STAFF TREATMEN CFR(s): 483.420(d)(If the alleged violation corrective action must be assed on observation interviews, the facility corrective action was potential reoccurrent.	when doing either of these ations included inservices for a timelines and one staff on uries. If the investigation did not the investigation did not the time the injury could have at least one client in the at least one client had not been at least one dient that not been are regarding client #5's attended they had only been told at with the Qualified Intellectual and (QIDP) indicated she had a vestigation; however, she formal staff interviews could I in determining the cause of a top of the course of t	W 15	Anytime an injury occurs of unknow origin the Residential Team Leader notify the Director of Program Oper and it will be investigated thorough staff involved will be interviewed w	will rations ly. All with Team t. Any n will ent. all he	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAIDSERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			A. BUILDING			COMPLETED		
NAME OF PROVIDER OR SUPPLIER		B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	0	1/30/2020		
KIMBERLY ROAD				15 N				
(X4) PREF TAC	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		LDBE COMPLE		
W 1	Continued From pa	ge 3	W 1	57				
	Appropriate correcti after an injury to clie	ve action was not taken to ent #5's left foot.		The state of the s				
	client #5 was seated	nome on 1/30/20 at 6:40am, d in his wheelchair in his g/foot was in an air splint or						
	revealed client #5 ha knows what happened have happened whe bed or while crawling home. Additional into	has a fractured foot and no one ened. The staff indicated it may hen he transferred out of his ing around on the floor in the interview indicated his foot was in one morning when he woke Intentionally Left Blank						
	notes/orders dated 1	f client #5's physician's /16/20 revealed, "Left tal fibula fracture LLEair						
	1/21/20 revealed, "Or was bathing [Client # left ankle was slightly seem to be in pain ar went to bed. On Januwas assisted in gettin noticed that [Client #8]	f a facility investigation dated in January 15, 2020, [Staff A] [5] and she noticed that his ir red. [Client #5] did not ind was monitored until he lary 16, 2020, [Client #5] ing out of bed. [Staff A] [5's] ankle was swollen. She Residential Manager's						
	Additional review of fi in the investigation inc regarding the injury to					The state of the s		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		2,000			THE CASE OF THE PROPERTY OF T	R	
34G329			B. WING			01/30/2020	
NAME OF PROVIDER OR SUPPLIER KIMBERLY ROAD				1503 KI	FADDRESS, CITY, STATE, ZIP CODE IMBERLY ROAD BERN, NC 28562		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 157	- "could have be transferred in and o around on the floor wheelchair time." - "maybe he could on the floor scooting. - "He transfers his and gets in and out independently. [Clie monitored during the his foot has gotten sattempting to get ou not injuries." Further review of the client #5 is active, can wheelchair using his floor and back into the fractured his ankle we task." Recommenda all staff on reporting reporting Level I injudid not include any of the prevent reoccurre. Interview on 1/30/20 Disabilities Profession to conducted the in	en from him getting ut of the chair, scooting or while he is having his out of d of hit his foot while he was g around." mself on and off the furniture of the bed at night nt #5] has to be closely e night because in the past, stuck in the bedrails when t of the bed but there were e investigation concluded that an move around in his selegs, and can transfer to the ne chair. "He could have when doing either of these tions included inservices for timelines and one staff on ries. The recommendations corrective actions to be taken nce of the injury to client #5. with the Qualified Intellectual onal (QIDP) indicated she had vestigation; however, no ad been taken to prevent the	W 1	57	Intentionally Left Blank		





February 11, 2020

Wilma Worsley-Diggs, Facilty Compliance Consultant I Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

RE: Follow-up Survey 1/30/20 Kimberly Road

DHSR - Mental Health

FEB 18 2020

Lic. & Cert. Section

Hello,

Please find enclosed the Plan of Correction for deficiencies cited during the survey referenced above.

If you need additional information or have any questions, please contact me at the number below.

Sincerely,

Leure Winstead, RD

Louise Winstead, RN Compliance Specialist – Plan of Corrections louise.winstead@monarchnc.org 252-289-6512

