STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G265	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAR RIVER	498 & 500 SEAN DRIVE GREENVILLE, NC 27834

(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 recertification and complaint survey was completed on 11/10/2020. Deficiencies were not cited as a result of the complaint survey for Intakes #NC00165949 and NC00170463. The complaint allegations were unsubstantiated.	W 000		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: The facility failed to assure the individual program plan (IPP) for 1 of 5 sampled clients (#3) included training in personal skills essential for independence in self-feeding as evidenced by observation, interview and record verification. The finding is: The interdisciplinary team did not consider training in self-feeding for 1 of 1 sampled clients that resides in the Daniels building that consumes a portion of his diet orally. During observations in the Daniels residence on 11/9/20 at 5:10pm, client #3 was being fed by staff #C while sitting in his car seat/booster chair. His food was pureed and consisted of green beans, pears, yogurt and honey thickened milk.	W 242		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G265	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAR RIVER	498 & 500 SEAN DRIVE GREENVILLE, NC 27834

(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 242	Continued From page 1	W 242		

The television was on and three of his peers were in the immediate area of the small day room area. Staff C repeatedly asked him to turn around and then she would spoon the food into his mouth. There were no attempts by staff C to encourage client #3 to feed himself.

During observations in the Daniels residence on 11/10/20 at 8:11am staff #B took client #3 into the large dayroom and assisted him into a large high chair with a tray. He had a plate with yogurt, applesauce and a nosey cup with honey consistency thickened milk. Staff #B explained to client #3 what food items he had for breakfast and then went to his right side and assisted him hand over hand to feed himself each bite of his breakfast. Staff #B assisted client #3 with picking up his cup and returning it to his tray.

Review on 11/10/20 of client #3's adaptive behavior inventory (ABI) dated 5/10/19 revealed client client requires partial assistance in being fed by staff, that he finger feeds independently and can feed himself with a spoon independently.

Review on 11/10/20 of client #3's IPP dated 3/5/20 revealed objectives to place objects in a container, match vocabulary words, select a number when given a variety of number cards, an objective to identify upper case letters and a behavior support program to improve interactions with peers. There were no daily living objectives identified for client #3.

Review on 11/10/20 of client #3's diet revealed he receives enteral feedings from 8pm-4:00am with 100 ml. of water after breakfast and after lunch. He receives 200 ml. of water over 1 hour at 9:30am, 12:30pm and at 16:30. He receives

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G265	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAR RIVER	498 & 500 SEAN DRIVE GREENVILLE, NC 27834

(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 242	Continued From page 2 puree fruit or pudding 3 tablespoons at breakfast. He receives 3 tablespoons of pureed vegetables, 1 fruit and yogurt at lunch. He receives 3 tablespoons of pureed vegetables, 1 fruit and yogurt for supper. He also receives 1-2 tablespoons of yogurt or pudding for his evening snack. Review on 11/10/20 of his diet card revealed client #3 should be in a seating option with upper back, attempt to use hand over hand to bring foods to mouth, If he refuses twice, then staff are to feed him. It was noted client #3 will gag if he is presented too much food at one time. Interview on 11/10/20 with client #3's teacher revealed he is very capable and should be given the opportunity to use his spoon and feed himself whenever possible in a chair that supports his posture. Further interview revealed a formal objective to teach client #3 how to consistently feed himself and use a cup had been considered, but is currently not in place. Interview on 11/10/20 with the qualified intellectual disabilities professional (QIDP) revealed client #3 did not have an objective to teach him to feed himself consistently. The QIDP explained that sometimes client #3 will be non-compliant during mealtime but these behaviors are addressed in his BSP and on his diet card.	W 242		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G265	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAR RIVER	498 & 500 SEAN DRIVE GREENVILLE, NC 27834

(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 249	Continued From page 3 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure client #4 received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of program implementation. This affected 1 of 5 audit clients. The finding is: Client #4 did not wear her AFO's as prescribed. During morning and afternoon observations in the Webb building on 11/9/20, client #4 was observed wearing an AFO on her right foot. Review on 11/9/20 of client #4's IPP dated 7/15/20 revealed that client #4 wears bilateral AFO's to prevent contractures and are worn throughout her waking day. Review on 11/10/20 of client #4's occupational therapy (OT) evaluation dated 7/22/20 revealed client #4 is supported by wearing bilateral AFO's. Interview on 11/10/20 with Staff A revealed client #4 wears a pulse oximeter device that is attached to her left foot. Staff A revealed that client #4 was not wearing her AFO on her left foot on 11/9/20 because it was causing the alarm to go off for her pulse oximeter device. Staff A confirmed that no adjustments were made to ensure client #4	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G265	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAR RIVER	498 & 500 SEAN DRIVE GREENVILLE, NC 27834

(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 249	Continued From page 4 continued to use her AFO as prescribed. Interview on 11/10/20 with the qualified intellectual disabilities professional (QIDP) revealed that client #4 wears bilateral AFO's. The QIDP revealed that if the AFO was removed due to the pulse oximeter devices alarm going off, adjustments should have been made and staff should have continued to attempt for client #4 to wear the AFO on her left foot. The QIDP confirmed client #4 should have been wearing AFO's on both feet.	W 249		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the Webb Building. The finding is: Precautions were not taken to prevent possible cross-contamination. During observations in the Webb Building on 11/9/20 through 11/10/20, staff were observed to wear face masks. Throughout the observations, multiple staff were observed wearing the face mask below their noses. Review on 11/9/20 of the facilities Pandemic Response Plan dated 3/6/20 revealed staff should wear the face masks and ensure the face	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G265	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAR RIVER	498 & 500 SEAN DRIVE GREENVILLE, NC 27834

(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 454	Continued From page 5 mask covers their mouth and nose. Continued review of the Pandemic Response Plan revealed staff in the facility have received training specific to face masks. Interview on 11/10/20 with the qualified intellectual disabilities professional (QIDP) revealed that staff are to wear face masks covering their mouths and noses regardless even if wearing a face sheild. The QIDP revealed that staff have been trained multiple times on PPE including face masks. The QIDP confirmed staff should wear their face masks to cover their mouths and noses.	W 454		