STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G009	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT CREEK	5709 US 70 EAST GOLDSBORO, NC 27534

(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 survey, a follow-up and a complaint survey was completed on 9/15/2020. There were no deficiencies cited as a result of Intake #NC00167527. The complaint allegations were unsubstantiated. Deficiencies were cited as a result of the recertification survey.	W 000		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to assist 1 of 6 audit clients (#1) in exercising her right to maintain her privacy in regard to her toileting needs. The finding is: Staff failed to assist client #1 in exercising her right to privacy. During observations at the facility on 9/14/20 from 3:40pm-6:00pm client #1 was in classroom #1 at the facility. At one point during observations client #1 was sitting in a recliner. Over the recliner was a sign, "Staff must take [client #1's name] to the bathroom every hour." When the surveyor went over to speak to client #1, she hid her head in her hands and turned away. Review on 9/15/20 of client #1's individual program plan (IPP) dated 1/17/20 indicated she inconsistently indicates the need for toileting.	W 125	W125: All clients will be assisted in exercising their rights. All staff, including Habilitation Specialists and QIDP will receive training on client rights for all people supported. This training will focus on effectively communicating through sign language on client #1's needs to toilet. Staff will be retrained on client #1's toileting schedule and will no longer use a sign on the wall for reminders. The sign has been removed. Monitoring to occur through monthly interaction assessments completed by either of the following: Administrator, QIDP, Social Worker, Habilitation Specialist DHSR-Mental Health OCT 0 6 2020 Lic. & Cert. Section	11-14-20

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

Linda Woodard | Administrator | 10-1-20

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 125	Continued From page 1 Additional review indicated she is on a informal toileting schedule and wears pull ups. Interviews on 9/14/20 with the habilitation specialist revealed the sign was posted over client #1's chair to remind staff to take her to the bathroom every hour to prevent toileting accidents. Interviews on 9/15/20 with the qualified intellectual disabilities specialist (QIDP) revealed because client #1 is nonverbal and relies on signs to communicate, the shift supervisor and QIDP wanted to make sure direct care staff were attentive to client #1's toileting schedule. She stated she had not considered this may draw unnecessary attention to client #1's toileting needs with regards to maintaining her dignity.	W 125		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and staff interviews, staff did not report an injury of unknown origin to the administrator for 1 of 6 audit clients (Client #30). The finding is: The facility failed to investigate the cause of foot injury for client #30.	W 153	W125: All injuries of unknown origin will be reported to the administrator through an incident report within 24 hours. Direct support staff will receive retraining on completing an incident report for all injuries reported to nursing. Nurses will assess the injury and document the assessment of the injury and treatment on the incident report and in the nursing notes at the time the injury was observed. Nurses will also document follow-up action in nursing notes until injury has healed. All staff in the nursing department will be retrained on this process. Monitoring to occur through quarterly medical chart reviews as assigned by Director of Nursing to RNs and LPNs.	11-14-20

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W 153	Continued From page 2 A review was conducted on 9/14/20 of client #30's nurse's notes. An entry made on 5/16/20 at 7:12 am by Nurse #1 read, "Notified by staff that during her [client #30] bath, [client #30's] right foot has brown bruises and is swollen." There were no other entries in May to record if client #30 had pain or discomfort to the foot; or follow up action on the extent of client #30's foot injuries. An additional review on 9/14/20 of the hospital's emergency department provider notes dated 6/16/20 at 9:24 pm indicated: Reports of bilateral foot swelling, right greater than left. Unsure when this started. No history of trauma reported that feet are red. Patient [client #30] ...does have some bruising to the right foot, swelling to the forefoot bilaterally. Wince when touch foot ...closed fracture of distal end of right fibula and tibia. Unspecified fracture morphology, initial encounter. The report also indicated that foot film revealed that client #30 had severe osteopenia from chronically not bearing weight. "May not have taken significant trauma to cause this injury." The review could not conclude if there were direct correlations between the foot injury on 5/16/20 and 6/16/20. Interview on 9/15/20 with Nurse A revealed that she always records new injuries reported by staff and would have written the incident on the shift report on 5/16/20. As a practice, Nurse A indicated that she would have went to the room to examine client #30's injuries but could not recall the outcome or if any other actions were taken. Interview on 9/15/20 with the director of nursing (DON) revealed that her expectations were that when a nurse documents a skin injury, there should be follow up and closure on the report.	W 153	W153 (con't) Monitoring will also occur daily by the charge nurse for each shift. Charge nurse will ensure nursing notes are entered timely and accurately on acute issues, to include injuries of unknown origin. Charge nurses will ensure the shift report for oncoming shift reveals clear documentation of acute issues for the shift ending. Once per week, the Director of Nursing will review shift reports for acute issues and will check behind charge nurses to ensure compliance.	

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W 153	Continued From page 3 She would also encourage the nurse to complete an incident report. Interview on 9/15/20 with the administrator revealed that there was no incident report for the 5/16/20 concerning client #30 and the facility did not initiate an investigation into injury of unknown origin.	W 153		
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 reviews and interviews, the facility failed to thoroughly investigate an injury of unknown origin involving 1 of 6 audit clients (#1). The findings are: Facility Management did not investigate an injury of unknown source to client #1. During observations in the facility from 1:15pm-2:15pm on 9/14/20 client #1 was noted to have a large bluish bruise on her forehead and a scratch about 2-3 inches long on her right forearm. She pointed to her arm and shrugged her shoulders. Review on 9/14/20 of client #1's individual program plan (IPP) dated 1/7/20 revealed client #1 is non-verbal and uses signs and gestures to communicate. Interview on 9/14/20 with the habilitation specialist revealed she was told client #1 moved	W 154	W154: All incidents of unknown origin will be thoroughly investigated within 24 hours of the assessment of injury. On 9/15/20, client #1's injury was reported via IRIS as a Level 2 with initiation of investigation to determine the source of injury. The investigation was completed with findings submitted via IRIS on 9/22/20. QIDP and social worker will be retrained on the process of monitoring all incident reports to determine if injury is known or unknown. This will include: monitoring all incident reports daily and monitoring for any incident reports that may occur over weekends or evenings. QIDP or social worker will report to administrator any incident reports that does not specify the origin of injury . Administrator will authorize immediate initiation of an investigation to determine the source of injury. Monitoring to occur through monthly quality indicator meetings. Participants will include: Administrator, QIDP, SW, DON, and Corporate QA. Further	11-14-20

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W 154	Continued From page 4 in bed and her gastrostomy tube attached to her enteral feeding hanging next to her bed leaned over and the pole hit client #1 on the forehead. When asked about the scratch on her arm, the habilitation specialist stated client #1 likes to sit on the end of her bed and that another staff told her that she scraped her arm on the end of the bed. Interview on 9/14/20 with the qualified intellectual disabilities professional (QIDP) revealed they were completing an incident report on these injuries and they were reported Monday September 13, 2020 and were not witnessed but happened sometime during the weekend. Review on 9/15/20 of the incident report dated 9/13/20 submitted to the facility indicates client #1 was sitting on her bed in her bedroom and her "feeding pump fell on the floor, not sure how she hurt her forehead." The Nurse had been contacted about these injuries on 9/13/20 and the guardian was contacted on 9/13/20 but there was no follow up on this incident. There are no staff statements, no examination of the environment and no evidence of any interviews with client #1 about how she was injured. Further interview on 9/15/20 with the QIDP confirmed there was no follow up with the direct care staff, the shift supervisor working on 9/13/20 or with client #1 regarding how she was injured.	W 154	W154 (con't) monitor to occur during weekly facility mangement team meetings as incident reports for the past week will be reviewed. These meetings occur every Monday morning.	
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		

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W 249	Continued From page 5 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, record reviews and interviews, the facility failed to ensure 3 of 6 audit clients (#1, #9 and #30) received continuous active treatment consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of increasing expressive communication skills and assistance with feeding. The findings include: 1. Direct care staff did not implement client #1's sign language program as written. During observations at the facility on 9/14/20 from 4:10pm-6:30pm and on 9/15/20 from 9:10am-10:15am, direct care staff did not sign to client #1. During one observation on 9/14/20 direct care staff asked client #1 to get up and walk to the bathroom. There were no signs used to communicate with client #1. During evening observations on 9/14/20 the habilitation specialist took out client #1's program book when the surveyor was asking questions about client #1's sign language skills. The habilitation specialist went over the signs in the program book and client #1 signed each one of the pictures when asked. Review on 9/14/20 of client #1's individual program plan (IPP) dated 1/7/20 revealed client	W 249	W249: 1. Staff will receive training on sign language with emphasis on specific signs used for client #1. Habilitation Specialist has created a training board for staff to become more familiar with signs specific for client #1. Staff will implement client # 1's sign language program throughout each day. 2. Staff will receive training on following all meal guidelines as written in each person's IPP. Emphasis will be placed upon offering liquids throughout meals for clients # 9 and #30 and for anyone else with a diagnosis of dysphagia. This training will also reveal the risks involved if clients with dysphagia consume the entire meal before drinking liquids.	11-14-20

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W 249	Continued From page 6 #1 is non-verbal and uses signs and gestures to communicate. Further review of her IPP revealed a sign language communication program, " When provided a sign language model of each sign, [client #1] will demonstrate 5 manual signs (bathroom, sleep, hurt, go and thank you) for 1 of 5 trials for 2 consecutive data sessions." Review on 9/15/20 of client #1's programs for the month of September 2020, confirmed out of 9 possible opportunities (excluding weekends and the labor day holiday) that staff took data on client #1's sign language objective 5 times. Review on 9/15/20 of client #1's speech evaluation dated 12/17/19 revealed she should be encouraged to use simple signs to communicate core vocabulary words. Further review confirmed she uses gestures, signs and vocalizations to communicate with others. Interview on 9/15/20 with the qualified intellectual disabilities professional (QIDP) revealed there needs to be additional training for staff to encourage the use of signs to communicate with client #1. 2. Facility failed to follow the meal guidelines for 2 of 6 clients (client #9 and client #30) on modified diets. a.) On 9/14/20, Client #9 was observed during dinner in Classroom 1 from 5:25 pm to 5:45 pm. Client #9 was fed by direct care staff (dcs) B and received a pureed diet with juice. The dcs B fed client #9, the entire meal before offering any sips to drink. Client #9 guzzled all her juice and observed coughing several times after swallowing	W 249	W249 (con't) Monitoring for implementation of all IPPs with focus on sign language for client #1 and mealtime procedures for clients # 9 and #30, will occur through interaction assessements and mealtime assessments. There will be at least four mealtime and four interaction assessments assigned to either of the following: administrator, QIDP, social worker, and/or habilitation specialists on a monthly basis.	11-15-20

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W 249	Continued From page 7 her juice. On the dining room table was an opened binder with meal guidance instructions. On 9/15/20, Client #9 was observed during breakfast in Classroom 1 from 8:23 am to 9:00 am. Client #9 was fed by dcs #1 and received a pureed diet with flavored water. The dcs #1 fed client #9 her entire meal before offering any beverage to drink. Review on 9/14/20 of the undated meal guideline in the binder for client #9 read: Give small sips of liquid throughout meal. Review on 9/15/20, Client #9's individual personal plan (IPP) dated 7/8/20 revealed diagnoses of moderate intellectual developmental disabilities, cerebral palsy and dysphagia. Interview on 9/15/20 with the dcs #1 regarding serving beverages last revealed, that client #9 does not like to take sips with her food. Interview on 9/15/20 with the QIDP revealed that clients with dysphagia diagnoses needed to alternate foods nd liquids. She mentioned that client #9 did not like to alternate with sips but acknowledged the current meal guidelines suggested to alternate. b.) On 9/14/20, Client #30 was observed during dinner in Classroom 1 from 5:50 pm to 6:10 pm. Client #30 was fed by dcs B a modified diet with a cup of fortified orange juice. The dcs B fed Client #30 all contents of her meal, before assisting her with drinking the juice. On 9/14/20 review of the undated meal guideline in the binder for client #30 read: Give small sips	W 249		

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W 249	Continued From page 8 of liquid throughout meal. Review on 9/15/20 of client #30's IPP dated 5/17/20 revealed that her diagnoses were profound intellectual developmental disabilities, scoliosis and dysphagia. Interview on 9/14/20 with the dcs B regarding holding beverages for clients until the end of the meal revealed, "I guess because that's the way I feed my son." The dcs B also acknowledged that she was a new employee. Interview on 9/15/20 with the qualified intellectual developmental professional (QIDP) revealed that clients with dysphagia diagnoses needed to alternate foods and liquids.	W 249		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to take measures to coordinate a nutritional consult for 1 of 6 audit clients (Client #25), to address weight loss issues. The findings are: The nutritionist was not contacted on the behalf of client #25's weight loss. Review of client #25's individual program plan (IPP) dated 2/2/20 revealed the following diagnoses: gastrostomy tube, dysphagia, cerebral palsy and seizure disorder. On 5/8/20 his feeding	W 331	W331: Administrator contacted consultant nutritionist on 9/15/20 to request input on changing diet order for client #25 to address weight loss. Administrator informed nutritionist that the Director of Nursing (DON) would send more information on the needs of client #25. DON consulted with nutritionist via email on 9/16/20 regarding client #25's weight loss. Nutritionist recommended changes to diet order and team agreed. New diet order was implemented on 9/16/20. Nutritionist has been cleared to begin visits to the facility to address all client's nutritional needs. She is scheduled to be onsite on 10/1/20. Team members will	11-14-20

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W 331	Continued From page 9 plan was updated by the physician assistant to a formula 60 ml/hr/pump continuously. His weight in May 2020 was recorded at 91.0 pounds. By July 2020 his weight was 93.4 and in August 2020 his weight was 92.8. His ideal desirable weight (IDW) was in between 100-115 lbs. Review on 9/15/20 of an email dated on 9/8/20 from the qualified intellectual disabilities professional (QIDP), revealed that client #25 was not included in the dozens of clients listed, who needed the nutritionist to review their charts. Interview with the Director of Nursing (DON) on 9/15/20 revealed that client #25 was not currently in his IDW and has went from 102.2 lbs. to 89.9 lbs. in the last year, with some months of weight stability. He has had two adjustments to his formula since a hospitalization in February 2020. With an ongoing treatment of a stage II pressure ulcer on his hip, the DON mentioned that they probably needed to get him on a supplement to help with weight loss and to help with healing the skin condition. Interview with the Administrator on 9/15/20 suggested that client #25 had been discussed by the team in last week's corporate quality indicator meeting for nutritional concerns. Currently their contracted consultant had not been onsite since the facility restricted visitors due to COVID-19. She believed that the nutritionist was aware of their concerns about client #25 and will contact her to make sure there was a way that his nutritional needs could be reviewed.	W 331	W331 (con't) will provide a list of nutritional needs for all clients to the nutritionist for the first onsite visit. For any future epidemics which may result in no onsite services from consultants. team members will communicate to the administrator unsuccessful attempts to contact consultants. Administrator will then attempt contact with the consultant to determine if needs can be met virtually instead of face-to-face. Monitoring of all client's weight status and nutitional needs will occur through monthly quality indicator meetings. Participants will include: administrator, QIDP, DON, social worker and corporate QA.	
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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W 436	Continued From page 10 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to ensure recommended components for the wheelchairs of 3 of 6 audit clients (#17, #29 and #30) were in good working order. The findings include: Facility management failed to ensure repairs were made to the wheelchairs of three clients. a) During observations in the facility on 9/14/20 of audit client #17, the surveyor was looking at the wheelchair she uses for mobility. When examining the brakes for this wheelchair, the left brake for client #17's wheelchair did not engage. Interview on 9/14/20 with client #17's assigned teacher in the classroom confirmed the left brake on client #17's wheelchair had been reported to facility management staff and had not been in working for over 2 months. Her laptray pad also would not fasten to her wheelchair tray. Further interview revealed this also needed to be replaced. Review on 9/14/20 of client #17's individual program plan (IPP) dated 1/5/20 revealed she is non-ambulatory and uses a tilt in space wheelchair for mobility. Additional review revealed client #17 depends on staff to maneuver her	W 436	W436: Wheelchair repairs have not been addressed timely due to COVID-19 restrictions as the Physical Therapist (PT) is home based at another RHA facility and was restricted from the Walnut Creek facility. As of 9/28/20, PT has been cleared for onsite visits to Walnut Creek. PT is scheduled to be at this facility from 10/5/20 to 10/9/20 and will address wheelchair repairs for clients # 17, 29, 30. All other wheelchair repair needs will be addressed during this week. For any future epidemics which may prevent timely repairs of adaptive devices, the facility will seek other means to address repair needs. Monitoring will occur through monthly unit safety meetings which addresses ongoing repairs not completed in a timely manner. Members of the safety committee will include: administrator, social worker, DON, QIDP, DSP supervisor, OT/PT Habilitation Assistant.	11-14-20

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W 436	Continued From page 11 wheelchair for mobility. Interview on 9/15/20 with the qualified intellectual disabilities professional (QIDP) revealed the recent COVID-19 epidemic had affected the facility's ability to get wheelchair components repaired, which included repairing the brakes on client #17's wheelchair and replacing her wheelchair tray pad. b.) During observation on 9/14/20 at 4:16 pm in classroom 1, the QIDP and direct care staff (dcs) B transferred client #29 from his wheelchair into the bed. When client #29's body was lifted out of the wheelchair, it rolled backwards slightly. Interview on 9/14/20 with the dcs B revealed that the brakes are broke on client #29's wheelchair and has already been reported. Interview on 9/14/20 with dcs C revealed that she normally helped make wheelchair repairs, but it was on hold due to COVID-19. Interview on 9/15/20 with the QIDP revealed that client #29 was already scheduled to get a new chair this year when the COVID-19 outbreak happened, so it was put on hold. She stated that the facility would find a way to get the wheelchair's brakes repaired in the meantime. c.) During observation on 9/14/20 at 4:12 pm in classroom 1, dcs B and the Habilitation Specialist, picked client #30 up from her wheelchair and transferred her into bed. During the transfer, the wheelchair moved because both brakes were not locked. Soon afterwards, staff had to transfer client #30 back into her wheelchair to transport to the medication room. It was	W 436		

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	34G009	A. BUILDING _____ B. WING _____	09/15/2020

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W 436	Continued From page 12 observed that dcs B did not need to unlock the brakes, before wheeling client #30, out of the room. Interview on 9/14/20 with the dcs C revealed that their several wheelchairs in the classroom in need of repairs.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow dietary orders for modified diets and did not provide all additional nutrition for weight gain diets for 2 of 6 audit clients (Client #9 and Client #30). The findings are: 1. Facility failed to served meals according to dietary orders for clients #9 and #30. a.) During observations on 9/14/20 at 5:25 pm for dinner, in classroom 1, client #9 was fed by direct care staff (dcs) #2 and did not receive double portions at meal. Client #9 was presented with a pureed meal of a meat, side dish and vegetable on a sectioned plate. The food resembled the same size portions of other non-audited clients observed during the meal and did not fill out the plate. An additional observation during breakfast on 9/15/20, client #9 was fed by dcs A and was only offered flavored water to drink and did not receive a chocolate mighty shake, juice or a	W 460	W460: All clients will receive meals according to dietary orders. Training will occur with all direct support staff and dietary staff. Dietary staff training will focus on diet consistencies and the difference between a ground and pureed diet. Dietary staff will be advised to not add thickener to food. Training will also include dietary staff's responsibility to ensure all diet orders are accurate for all clients. A review of diet order inconsistencies for clients # 9 & #30 on 9/14/20 and 9/15/20 will be reviewed with dietary staff. Direct support staff training will focus on their responsiblity to ensure the diet order is accurate before the meal begins. If diet order is not accurate, staff will alert dietary so the diet order can be corrected. Staff will be reminded to double check the diet order card and ensure the diet order and guidelines are implemented during the meal. A review of diet order inconsistencies for clients #9 and #30 on 9/14/20 & 9/15/20	11-14-20

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W 460	Continued From page 13 double portion of pureed turkey and cheese. Review on 9/15/20 of the individual program plan (IPP) dated on 7/8/20 revealed that client #9 was on a weight gain diet and should receive double portions at meals, with water, juice and a mighty shake chocolate flavored at breakfast. Interview with dcs B on 9/14/20, revealed that she was not aware that client #9 should have received double portions. Interview with the Director of Nursing (DON) on 9/15/20 revealed that her expectations were for staff to follow dietary orders at meals. b.) During observation on 9/14/20 at 5:50 pm for dinner in classroom 1, client #30 was fed by dsc B. Her meal was served on a sectioned plate, and the food had a soft consistency texture like creamed potatoes and resembled pureed food. Client # 30 received fortified orange juice with meal but did not get water. Review on 9/14/20 of the IPP dated 5/17/20 revealed that client #30 was on a weight gain ground diet, with water at meals. Review on 9/14/20 of a dietary texture card in the classroom indicated that a ground diet resembled grains of rice. Interview with dcs Bon 9/14/20, revealed that she did not know what kind of diet texture that client #30 was supposed to receive, since it was already prepared in the kitchen. The dsc B glanced at the meal card on the table, which read a ground texture. The dcs C sat across the table and stated that client #30's meal looked pureed.	W 460	W460 (con't) will be reviewed with staff. Training will also include a review (with pictures) of the difference between a cut, ground, and pureed consistency. Monitoring will occur through monthly assigned mealtime assessments with a minimum of four per month. These assessments will be assigned to either of the following: administrator, QIDP, social worker, or habilitation specialists. Corporate QA staff will be providing mealtime assessments during QA audit scheduled for 10/2/20.	

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W 460	Continued From page 14 Interview with Habilitation Specialist (HS) on 9/14/20 regarding client #30's diet revealed that it was supposed to be a grade up from pureed. The HS revealed the meal card, which read a ground diet. On 9/14/20, the cook came to classroom 1 and was interviewed. She looked at client #30's food and stated that she prepared a ground diet, but added thickener to it, to hold the food together once it was commercially processed to ground texture.	W 460		
W 489	DINING AREAS AND SERVICE CFR(s): 483.480(d)(5) The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to feed 1 of 6 audit clients (Client #25) with gastrostomy tube in an upright position. The finding is: Facility did not assure that client #25 sat during feeding with an elevated head at 30 degrees. During observations on 9/14/20 at 2:35 pm, client #25 was in a hospital bed, laying in the middle of the bed, below the area where the head of the bed had been elevated at 30 degrees. His upper body did not lay straight and he had several large soft cushions surrounding him. His feeding pump was on with the formula rate at 60 ml/hr.	W 489	W489: All clients will eat in an upright position as specified in each client's IPP. Team members will assess challenges in keeping client #25's head elevated at 30 degrees during continous feedings and explore alternative actions to ensure client's safety. Consults from physical therapist on positioning options and from nutritionist on alternative feeding schedules will be pursued. Training will be provided to direct support and nursing staff on on consistent monitoring of all clients to ensure they are in an upright position during feedings. Emphasis will be placed on close monitoring to ensure client #25 has elevation of head at 30 degrees at all times. Staff will receive additional training in the event of any revisions to client #25's feeding schedule or positioning.	11-14-20

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W 489	Continued From page 15 During observations in classroom 1 on 9/14/20 from 4:00 pm until 6:15 pm, client #25 was resting in a recliner chair, that sat upright against the wall. Client #25 was observed slouched down in the recliner, with his left side of his head resting on two pillows that were across the armrest. His feeding tube was next to the chair and turned on, delivering formula at 60 ml/hr. The Habilitation Specialist (HS) walked over to the chair, to adjust his pillows under his head, but allowed him to lay in a slouched position. During observations on 9/15/20 at 7:10 am and at 9:10 am, client #25 remained in bed without his head elevated at 30 degrees. His body was positioned in the middle of the mattress and his head rested on a pillow. Review of client #25's individual person plan (IPP) dated 2/2/20 revealed the following diagnoses: gastrostomy tube, dysphagia and cerebral palsy. His equipment was adapted and required a hospital bed with padded raised side rails, with head of bed elevated at 30 degrees during feeding due to risk of aspiration. Interview with the first shift supervisor on 9/14/20 when she came in the room to get him up, was that client #25 had been in bed, half of the day. She commented that he always slid down in the bed, regardless of how he is positioned. She expressed that client #25 seemed to be more comfy laying crooked and would holler if moved. The supervisor acknowledged that his head was no longer at 30 degrees but that he did not have issues aspirating. Interview with the Director of Nursing (DON) on	W 489	W489 (con't) Monitoring to occur through nightly safety bed checks every 30 minutes. Administrator, QIDP, social worker or DON will review bed checks for accuracy once per week. Additional monitoring to occur through monthly interaction assessments with a minimum of four per month by either of the following: administrator, QIDP, social worker, or habilitation specialists. Daily observations on proper positioning during feedings will occur by the DSP supervisor, nursing staff, and OT/PT habilitation assistant. Any positioning issues will be immediately addressed.	

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W 489	Continued From page 16 9/15/20 revealed that the facility would have to do more to keep client #25's head where it is elevated at 30 degrees.	W 489		

RHA
HEALTH SERVICES, LLC

October 1, 2020

Ms. Esther Moore, BSW
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, North Carolina 27699-2718

RE: Plan of Correction for recertification survey on 9/14/20 to 9/15/20
Walnut Creek, 5709 U.S. Hwy 70 East, Goldsboro, NC 27534
MHL# 096-009

Dear Ms. Moore:

Enclosed is the Plan of Correction for the tags cited during the recertification survey at Walnut Creek.

Please do not hesitate to call if you have questions regarding this matter.

Sincerely,

Linda Woodard

Linda Woodard
Administrator

Enclosures

Walnut Creek
5709 US 70 East * Goldsboro, NC 27534
919.778.3524 Voice 919.778.9619 Fax