STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G044	A. BUILDING _____ B. WING _____	R 09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH AVENUE HOME	**105 EAST HEATH AVE SMITHFIELD, NC 27577**

(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 9/13/21 for deficiencies cited on 5/27/21. Five deficiencies were corrected; However, two deficiencies remain out of compliance and two new deficiencies were found. The facility remains out of compliance.	{W 000}		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure privacy was maintained during personal care. This affected 1 of 6 audit clients (#1). The finding is: During observations at the day program on 9/13/21 at 10:36am, Staff B was observed to take client #1 to the bathroom. The door to the bathroom remained open while client #1 went into the bathroom stall. Once exiting the stall, client #1 was observed to stand in the stall with the door open, with his pants and adult briefs down around his knees. Staff B was observed to stand in the open door of the stall and assist client #1 with adjusting his clothes. During the observation, two other clients were observed to enter and exit the bathroom, and other clients at the day program were observed to walk up and down the hall past the open bathroom door. Review on 9/13/21 of client #1's Adaptive Behavior Inventory (ABI) dated 10/7/20 revealed that client #1 has no independence in the area of	W 130		

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

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W 130	Continued From page 1 closing the bathroom door for privacy. Interview on 9/13/21 with the qualified intellectual disabilities professional (QIDP) confirmed that client #1 is not independent in closing the door for privacy. The QIDP confirmed that staff should have ensured the stall door and bathroom door were closed when client #1 was in the bathroom to give him privacy.	W 130		
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 in the day program classroom (#1, #2, #3, #4, #5 and #6). The findings are: A. During observations at the day program on 9/13/21 at 10:45am, client #1 was observed to exit the bathroom after toileting. Staff B prompted client #1 to wash his hands, but he refused. Staff B escorted client #1 back to the classroom. Once in the classroom, client #1 was observed to spit multiple times on the floor and table he was sitting at. During the observations, Staff A and Staff B were observed to give client #1 a wooden box with various manipulative's on it, which he touched or pushed away. At 10:52am, Staff A was observed to give client #1 a box of wooden blocks. Client #1 was observed to pick up several of the blocks and put them in his	W 454		

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W 454	Continued From page 2	W 454		

mouth. Staff A took the blocks from client #1 and put them back in the activity cabinet. At 10:58am, Staff B was observed to give client #1 some of the markers that his peer was using that was sitting at the table beside him. Client #1 was observed to put several of the markers in his mouth. Staff B took the markers from client #1 and gave them back to his peer. At 11:13am, Staff A was observed to put the markers back in he box and put them in he activity cabinet. At no time during the observations was client #1's hands sanitized, nor was the table and activities sanitized.

Interview on 9/13/21 with the qualified intellectual disabilities professional (QIDP) confirmed that client #1's hands should have been sanitized, the table and floor should have been sanitized after client #1 spit on them, and the activities should have been sanitized after client #1 touched them and put them in his mouth.

B. During observations at the day program on 9/13/21 at 11:24am, Staff B was observed to assist client #3 with cutting her sandwich using a rocker knife and hand-over-hand assistance. Staff B was wearing a pair of latex gloves and was observed to pick client #3's sandwich up with her hands to pull the pieces apart. At 11:27am, Staff B was observed to assist client #4 with cutting her sandwich up, using a rocker knife and hand-over-hand assistance. Staff B was then observed to use her gloved hands to pick up the sandwich and pull the pieces apart. At 11:30am, Staff B was observed to assist client #1 and client #2 with cutting their sandwiches up, using a rocker knife and hand-over-hand assistance. Staff B was observed to use her gloved hands to pick up both sandwiches and pull the pieces

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W 454	Continued From page 3 apart. During the observation, Staff B was observed to utilize the same pair of gloves. Interview on 9/13/21 with the QIDP confirmed that Staff B should have changed her gloves after assisting each client to prevent cross contamination.	W 454		
{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 reviews, and interviews, the facility failed to ensure 2 of 6 audit clients (#1 and #2) received their specially prescribed diet as indicated. The findings are: A. During observations at the day program on 9/13/21 at 11:30am, client #1 was observed eating a meat and cheese sandwich for lunch. Staff B was observed to assist client #1 with cutting his sandwich. Several pieces of the sandwich were approximately two inches or larger in size. Review on 9/13/21 of client #1's individual program plan (IPP) dated 9/3/21 revealed a diet that consists of foods being cut into 1/2 - 1 inch bite size pieces. Interview on 9/13/21 with the qualified intellectual disabilities professional (QIDP) confirmed client #1's sandwich should have been cut into 1/2 - 1 inch bite size pieces as his diet indicates.	{W 460}		

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{W 460}	Continued From page 4 B. During observations at the day program on 9/13/21 at 11:30am, client #2 was observed eating a meat and cheese sandwich. Staff B was observed to assist client #2 with cutting her sandwich into pieces. Several pieces of client #2's sandwich was larger than two inches in size, with one piece being the length of the side of the sandwich. Review on 9/13/21 of client #2's IPP dated 3/29/21 revealed a diet that includes all meats chopped into 1/2 inch pieces. Interview on 9/13/21 with the QIDP confirmed that client #2's sandwich should have been cut into 1/2 inch pieces as her diet indicates.	{W 460}		
{W 473}	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure all foods were served at an appropriate temperature. This potentially affected all clients in the day program classroom (#1, #2, #3, #4, #5 and #6). The finding is: During observations at the day program on 9/13/21 at 11:15 am, Staff B warmed a plastic container of tomato soup in the microwave for thirty seconds. Staff B removed the container from the microwave, stirred the soup and replaced the lid on the container. Staff B then placed the container in a lunch bag. At 11:21am Staff B returned to the classroom where the	{W 473}		

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{W 473}	Continued From page 5 clients were having lunch and removed the soup from the bag and sat it on the table. At 11:45am the soup was served to the clients. At no time was the temperature of the soup checked nor was the soup reheated. Interview on 9/13/21 with the qualified intellectual disabilities professional (QIDP) confirmed the temperature of the foods should have been checked and the food should have been reheated if needed.	{W 473}		