STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G004	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'BERRY NEURO-MEDICAL TREATMENT CENTER	400 OLD SMITHFIELD RD GOLDSBORO, NC 27530

(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 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 7 audit clients (#3 and #2) were provided the opportunity of choice. The findings are: A. During dinner observations on 2/8/22 and breakfast observations on 2/9/22 in area 77, staff poured the liquids for client #3. Further observations revealed at no time was client #3 given the opportunity to pour any of his liquids. B. During dinner observations on 2/8/22 and breakfast observations on 2/9/22 in area 77, staff poured the liquids for client #2. Further observations revealed at no time was client #2 given the opportunity to pour any of his liquids. During an interview on 2/9/22, the qualified intellectual disabilities professional (QIDP) stated clients #3 and #2 should have been given the opportunity to pour their own liquids.	W 247		
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 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	W 249		

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
	34G004	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 1 plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 7 clients (#7 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of medication administration and use of gait belt. The findings are: A. During morning medication administration observations on 2/9/22 at 7:38am, in area 77 the licensed practical nurse (LPN) spoon fed client #7 his medications. Further observations revealed at no time was client #7 prompted to spoon feed himself his own medications. During an interview on 2/9/22, the LPN stated she spoon fed client #1 his medications due to the fact he was distracted during his medication administration. Review on 2/9/22 of client #7's nursing assessment dated 12/14/21 revealed "Direct verbal cue - Inform individual what nurse wants him...to do." Review on 2/9/22 of client #7's occupational assessment dated 12/21/21 stated, "He feeds himself...independently." During an interview on 2/9/22, the unit consultant stated client #7 can hold the spoon in his right hand and then staff will talk him to feed himself.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G004	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'BERRY NEURO-MEDICAL TREATMENT CENTER	**400 OLD SMITHFIELD RD GOLDSBORO, NC 27530**

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W 249	Continued From page 2 During an interview on 2/9/22, the qualified intellectual disabilities professional (QIDP) revealed client #7 can feed himself and he should have been given the opportunity to do so. B. During observations throughout the survey on 2/8/22 - 2/9/22 in area 76, client #5 was observed wearing a gait belt when ambulating. During the observations, staff were observed to hold the gait belt with their hand tucked into the side of the gait belt, or walk behind client #5 with their hands tucked under his arms. Review on 2/9/22 of client #5's individual program plan (IPP) dated 8/12/21 revealed client #5 is supported with the use of a gait belt "throughout his routine for staff to assure his safety providing hands on assistance and manage his unsteadiness while walking." Interview on 2/9/22 with Staff C revealed staff are trained to assist clients with ambulating by holding the loop on the back of the gait belt while walking beside the client. Interview on 2/9/22 with the facility's physical therapist confirmed that staff, when assisting client #5 with ambulating, should hold the loop on the back of the gait belt and walk beside him.	W 249		