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 _____	11/30/2021

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	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 plan. 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 (#2 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 dining and adaptive equipment use. The findings are: A. During lunch observations in the Daniel Building on 11/29/21 at 12:25pm, Staff A sat at a tall table in the dining room while client #2 was seated in a short boxed chair directly in front of her. Staff A held a sectioned plate in her hand which contained pureed food, scooped the food onto a coated spoon with a built up handle and handed the spoon to the client. Client #2 took the spoon and placed the food in his mouth. He was assisted to consume his thickened liquid in the same manner. The client was not prompted or encouraged to scoop his food/drink. During dinner observations in the Daniel Building on 11/29/21 at 5:15pm, Staff B assisted client #2 to sit in a short boxed chair at a small table while	W 249	Preparation and/or execution of this plan of correction does not constitue admission or agreement by the provider or the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of Federal and State laws. W 249: Plan of correction for program implementation. Tar river is putting new training inservices to help staff with using all adaptive equipment and feeding techniques on a consistent basis. These will be broken down into two catergories one for use of adaptive equipment and one for proper feeding techniques. Monitoring will be completed formly through monthly through feeding and interatction assessments. Informally administration staff will perform daily walkthroughs.	1/15/2022

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

Christopher J. Harden | Administrator | 12/08/2021

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.

Plans of Mental Health

DEC 10 2021

Lic. & Cert. Section

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W 249	Continued From page 1 the staff fed the client his entire pureed meal and thickened liquid from small plastic cups using a coated spoon with no built up handle. The client was not encouraged to feed himself. During breakfast observations in the Daniel Building on 11/30/21 at 8:18am, Staff I assisted client #2 to sit in a short boxed chair directly in front of her while the she sat at a tall table in the dining room. As Staff I held a sectioned plate in her hand which contained pureed food, she assisted client #2 to scoop his food from the plate and place the spoon in his mouth. His thickened drink was consumed in the same manner. During the meal, a coated spoon with no built up handle was utilized. Interviews on 11/29 - 11/30/21 with all staff involved revealed they normally assist or feed client #2 in the manner observed. Additional interview with Staff I indicated they try to encourage client #2 to be more "independent" during meals. Review on 11/29/21 of client #2's Therapeutic Feeding Techniques dated 11/19/20 revealed a diet texture of "pureed and 45 cc formula thickened honey consistency". The guidelines noted a built up handle spoon and cup w/o a lid should be utilized. Additional review noted client #2 should be "seated in his wooden chair with his tray." The specific techniques included, "...Provide built up handle spoon and promote him to reach and grasp it. If [Client #2] does not attempt grasp the spoon then provide graduated guidance and/or HOH assistance to grasp it and assist in scooping and tasting, to provide motivation. If he will not hold it, the trainer should scoop for him and hold the spoon up toward him	W 249		

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W 249	Continued From page 2 and prompt him to grasp it and pull it to his mouth. (backward chaining). For drinking Honey thick liquids use same technique, graduated guidance and or HOH assistance..." Further review of client #2's IPP dated 2/4/21 revealed an objective, "When presented with food with verbal prompting from trainer, he will attempt to feed himself independently for 3 out of 4 trails corrects for three consecutive months." The objective was implemented on 11/16/20. Additional review of the plan noted, "Continue using built up handle spoon during oral feeding to increase his active participation and facilitate scooping independently." Interview on 11/30/21 with the facility administrator revealed client #2's wooden chair with a tray was broken and they are in the process of scheduling the repairs. The administrator noted in the meantime, staff should use the short boxed chair and have client #2 sit at a short table in the dining room. Additional interview confirmed the specific techniques provided in client #2's therapeutic feeding guidelines should be followed as written. B. During observations in the Webb Building on 11/29/21 from 11:15am until 12:30pm, client #5 was observed not wearing his glasses. On the afternoon of 11/29/21, client #5 returned from an appointment at approximately 4:30pm and did not have his glasses on. Client #5's glasses sat on his dresser and were not placed on the client at any time between 4:30pm and 5:45pm. Further observation on 11/30/21 revealed client #5 woke up around 9:10am and was placed in his high chair. Client #5's glasses were placed on	W 249		

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W 249	Continued From page 3 him at this time. Client #5 was given a bath at 9:15am and his glasses were placed on his dresser and not put back on him after this time. Review on 11/29/21 of client #5's optometry evaluation dated 8/12/21 revealed an order to "wear glasses full time as much as possible while awake". Further review on 11/29/21 of client #5's IPP (dated 5/26/21) under adaptive equipment revealed "glasses during waking hours as tolerated". During an interview on 11/30/21 the Qualified Intellectual Disabilities Professional (QIDP) revealed client #5 should wear glasses at all times while awake and that staff should put them back on him even if he takes them off.	W 249		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications remained locked except when being administered. The findings are: A. During observations in the Daniel Building on 11/30/21 at 7:31am and 7:47am, Nurse D left a small bin containing seven medications belonging to various clients on top of the locked medication cart. During these times, the nurse left the medications unsecured to obtain a trash bag from another room and again to give a client their	W 382	W 382 Plan of correction: RHA Tar River will make training inservices for all medical staff that goes over medication storage rules. Each medical staff member will sign inservice sheet after training is completed. This will be monitored monthly through interaction assessments and informally by admin staffing completeing daily walk throughs.	1/15/2022

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W 382	Continued From page 4 morning medications in an adjacent room. The medications in the small bin were unsecured and accessible to anyone in the area. Immediate interview on 11/30/21 with Nurse D revealed the medications in the bin had been removed from a small locked refrigerator and placed in the bin to give to various clients during the morning medication pass. Additional interview indicated these medications did not need to be locked while the nurse left the area. Review on 11/30/21 of the Nursing Policy and Procedures Manual (Revised February 2016) revealed, "Medications will not be left unattended in the presence of a person." Additional review of the manual noted, "Compartments containing medications are locked when not in use. Trays or carts used to transport items are not left unattended. (Compartments include, but are not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes.)..." Interview on 11/30/21 with the Director of Nursing confirmed medications removed from the locked refrigerator should be locked in the medication cart while waiting to be administered. B. During medication aministration in the Webb Building on 11/29/21 at 11:30am, Nurse K was administering noon medications. Nurse K had a plastic bin sitting on top of the medication cart with multiple client's medications inside. Nurse K walked away to pass medications to clients and left the bin on top of the cart unsecured. During an immediate interview on 11/29/21, Nurse K revealed that she pulled those	W 382		

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W 382	Continued From page 5 medications from the refrigerator and would place them back once the noon medication pass was complete. Review on 11/30/21 of the Nursing Policy and Procedures Manual (Revised February 2016) revealed, "Medications will not be left unattended in the presence of a person." Additional review of the manual noted, "Compartments containing medications are locked when not in use. Trays or carts used to transport items are not left unattended. (Compartments include, but are not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes.)..." During an interview on 11/29/21 the team lead registered nurse revealed that the medications should have been pulled individually and should not have been placed on top of the medication cart unsecured.	W 382		