STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

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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 1 of 6 audit clients (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program implementation. The findings are: A. Observations on 7/11/22 in the home revealed staff pushing client #1's wheelchair without prompting or allowing her wait time to self-propel. At 4:49pm in the living room, client #1 stated that she wanted to move closer to the television. The residential manager (RM) immediately pushed client #1's wheelchair across the room closer to the television. No wait time or prompting to self-propel were observed. At 7:01pm in the dining room, client #1 stated that she was finished with her meal. Staff B immediately pushed client #1's wheelchair away from the table and out of the dining room. No wait time or prompting to self-propel were observed. Observations on 7/12/22 in the home revealed staff pushing client #1's wheelchair without	W 249		

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

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W 249	Continued From page 1	W 249		

prompting or allowing her wait time to self-propel. At approximately 7:40am, Staff C entered the living room and pushed client #1's wheelchair to the medication administration room. Further observation revealed Staff C pushing client #1's wheelchair into the dining room. No wait time or prompting to self-propel were observed. At approximately 9:15am, Staff C pushed client #1's wheelchair from the table and exited the dining room. No wait time or prompting to self-propel were observed.

Review of client #1's IPP dated 5/22/22 revealed that client #1 should be allowed to independently propel with a 15 minute wait time after client #1 stops self-propelling, offering prompting for movement before offering assistance.

Review of the Occupational Therapist's (OT) progress note dated 4/9/22 revealed that client #1 should propel independently with a wait time of 15 minutes, after she stops self-propelling, before intervening for assistance.

Review of client #1's Behavior Support Plan (BSP) dated 4/20/22 revealed that graduated guidance and redirection should be utilized when completing tasks, including self-propelling. The guidance should include a wait time of 15 minutes once client #1 stops self-propelling. In addition, staff should "verbally encourage and prompt" client #1 to propel herself throughout the day without assistance.

Interview on 7/12/22 with Staff B revealed that client #1 moves very slowly and may not attempt to move her wheelchair.

Interview on 7/12/22 with the Team Lead (TM)

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W 249	Continued From page 2 revealed that staff assist client #1 in propelling when needed. When asked what client #1's graduated guidance guidelines were, the TM was unsure of the guidelines but offered to ask the RM. The RM stated that staff help client #1 to move through the home. The RM stated that client #1 should be encouraged to self-propel. When asked if there was a waiting time once client #1 stops self-propelling before staff should help, the RM stated that she would need to locate the exact information. The RM then stated that she thought it was 15 minutes. B. Observations on 7/11/22 and 7/12/22 in the home revealed that client #1 was not offered a consistent, two-hour toileting schedule. On 7/11/22 from 4:00pm to 7:30pm, client #1 was not assisted or prompted to go to the toilet. On 7/12/22 from 6:30am to 9:11am, client #1 was not assisted or prompted to go to the toilet. Review of client #1's IPP dated 5/22/22 revealed that client #1 followed a two-hour toileting schedule. Review of client #1's BSP dated 4/20/22 revealed that client #1 had 23 toileting accidents within a 10-month time span in the past year. The BSP further revealed that client #1 has a history of toileting accidents and wears pull-ups. Review of client #1's toileting schedule documentation revealed that client #1 had used the toilet at 7:00pm on 7/11/22. Interview on 7/12/22 with Staff A revealed that client #1 has a two-hour toileting schedule. Staff A stated that "everyone pretty much here does so	W 249		

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W 249	Continued From page 3 we try to offer a bathroom break about every two hours or more". Staff A further stated that client #1 could say if she needs to use the bathroom. Interview on 7/12/22 with the RM revealed that client #1 could tell staff if she needs to go to the bathroom. When asked why a toileting schedule was needed, the RM stated that it was an approximate time for staff to offer bathroom breaks. When asked about the purpose of the two-hour toileting documentation, the RM stated that it was to record if client #1 was dry, wet, taken to bathroom or refused.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the proper wearing of face masks. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the facility. The findings are: A. During afternoon observations on 7/11/22 at a local park at 11:43am, Staff A and Staff D exited the van which had six clients riding in it. Further observations revealed neither staff Staff A or Staff B where wearing face masks. At no time did Staff A or Staff D put on a face mask. The two staff and the six clients remained at the local park until 1:30pm. Further observations indicated	W 340		

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W 340	Continued From page 4 when Staff A and Staff D got back on the van with the six clients to return to the home, they were not wearing face masks. B. During morning observations in the home on 7/12/22 at 7:00am, Staff C entered the home. Further observations revealed Staff C was not wearing a face mask. Staff C was observered walking around the house, talking to the six clients and her co-workers. Additional observations revealed Staff C putting on a face mask at 7:11am. During an interview on 7/12/22, Staff C stated she does not have to wear a face mask due to the fact she is fully vaccinated. When asked why she put on a face mask, Staff C reported it was due to her seeing the two surveyors wearing face masks. Review on 7/12/22 of the facilities policy After COVID Residential Plan LTSS Update (date 3/3/22) states, "Personal Protective Equipment (PPE) Staff: Staff should wear PPE consistent with the most recent agency guidelines. In general, fully vaccinated staff should continue to wear source control (appropriate PPE) while at work....". During an interview on 712/22, the Team Leader (TL) stated there has been miscommunication about the policy and staff should be wearing face masks while in the home and on the van.	W 340		
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	W 382		

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W 382	Continued From page 5 administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The finding is: During afternoon medication administration on 7/11/22, at a local park at 12:03pm, Staff A removed three pill bubble packs from a small back pack. Further observations revealed the back pack did not have a lock on it. Additional observations revealed the small back pack remained on a picnic table until 12:58pm, when a client picked it up and took it to the van where it was placed between the two front seats. Further observations indicated there where three clients sitting within close proximity of the unlocked small back pack which contained the three bubble packs. During an immediate interview on 7/11/22, Staff A reported she did not realize the medications where unlocked. Further interview revealed Staff A has been working in the home for three years and medications have always been transported on outings in this manner. During an interview on 7/11/22, the Team Leader (TL) confirmed the medications should not have been unlocked while the clients where out on an outing in the community.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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,	W 436		

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W 436	Continued From page 6 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 interviews, the facility failed to ensure 1 of 6 audit clients (#1) was taught to use and make informed choices to wear her glasses. The finding is: Observations on 7/11/22 at the park from 11:44am to 1:15pm revealed that client #1 was not wearing her glasses. At no time did staff prompt her to wear her glasses. Observations in the home from 4:00pm to 7:30pm revealed that client #1 was not wearing her glasses. At no time did staff prompt her to wear her glasses. Review on 7/12/22 of physician's orders dated 7/9/21 revealed that client #1 had mild cataracts with orders for new glasses. The orders further stated that client #1 was encouraged to wear glasses more often. Interview on 7/12/22 with the residential manager (RM) revealed that client #1 wears glasses as she chooses. When asked if glasses were in the doctor's orders, the RM stated that she would need to locate the orders. Interview on 7/12/22 with the Team Lead (TL) revealed that client #1 may wear glasses for part of a day and then take them off. The TL stated that she wears glasses by choice. When asked if she should be prompted to wear her glasses, the TL stated that it staff can not make clients do anything and that all clients have choice.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 441		

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W 441	Continued From page 7 and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 7/11/22 revealed four fire drills were conducted on third shift at: 12:08am, 12:01am, 12:00am and 5:03am. During an interview on 7/12/22, the Residential Manager (RM) confirmed the fire drills conducted on third shift were not conducted at varied times. During an interview on 7/12/22, the Team Leader (TL) stated third shift hours are 11:00pm until 7:00am.	W 441		
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 interviews, the facility failed to ensure clients #4 and #5 diets were provided as prescribed. This affected 2 of 6 audit clients (#4 and #5). The findings are: A. During lunch observations on 7/11/22 at a local park at 12:09pm, Staff A put an undetermined amount of white powder from a small plastic baggie and placed it into two	W 460		

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W 460	Continued From page 8	W 460		

different cups for client #5. Further observations revealed one cup was see-through and the other was not. The cup which was see-through revealed the white powder was sitting on the bottom of the cup. At no time was the white powder stirred in either cup. The liquid in the see-through cup was s thin consistency. At 12:10pm, while client #5 was drinking he coughed two times. At no time did Staff A ensure that client #5's liquids were the correct consistency.

Review on 7/11/22 of client #5's Individual Program Plan (IPP) dated 6/28/21 stated, "Honey thick liquids to prevent choking".

During an interview on 7/11/22, Staff B revealed two scoops of the Thick-It Powder are placed into client #5's cups, they are then stirred, then wait and then add another scoop of the Thick-It Powder. Further interview revealed client #5's liquids are a honey thick consistency. Staff B stated client #5 drinks honey thick consistency liquids at each meal.

During an interview on 7/112/22, the Residential Manager (RM) revealed client #5's liquids are to be honey thick due to his choking risk.

B. During breakfast observations in the home on 7/12/22 at 8:43am, client #4 had a whole piece of toast on her plate, which was placed on the table. Further observations revealed client #4 consumed the toast with four bites. At no time was client #4's toast cut up into bite size pieces.

During an interview on 7/12/22, Staff A confirmed all of client #4's food are to cut into bite size pieces prior to being bought to the table.

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W 460	Continued From page 9 Review on 7/11/22 of client #4's IPP dated 8/23/21 indicated, "...regular diet with all of her food cut into bit-sized pieces before coming to hr table. This is to help prevent choking as [Client #4] does not like to take time to cut her food and eating fast". During an interview on 7/112/22, the RM revealed client #4's foods are to be cut up into bite size pieces due to her choking risk.	W 460		