DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	02/21/2023

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 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1's record content was accurate and updated regarding mobility and vision. This affected 1 of 4 audit clients (#1). The finding is: Review on 2/20/23 of client #1's Individual Program Plan, dated 9/6/22, revealed client #1 was recently admitted. The IPP stated that client #1 normal vision and was ambulatory. Observations throughout the survey on 2/20-2/21/23 in the home revealed client #1 utilizing a Geri-Chair for all mobility needs. Client #1 was not observed to ambulate. During meal observations throughout the survey on 2/20-2/21/23, staff used hand over hand prompting to assist client #1 to locate dining items. Review on 2/21/23 of client #1's Seating and Mobility Clinical Evaluation, dated 4/15/22, revealed a need for a Geri-Chair and tray to allow client #1 to sit upright. Review on 2/21/23 of client #1's physical therapy (PT) evaluation, dated 4/28/22, revealed client #1 had decreased rapidly over the past year following a hospitalization. The PT evaluation further stated that client #1 should remain in the Geri-Chair for activities and mobility.	W 111		

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.

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W 111	Continued From page 1 Review on 2/21/23 of client #1's doctor orders, dated 4/12/22, revealed a prescription for a Geri-Chair. Review on 2/21/23 of client #1's Feeding Guidelines revealed that staff should help client #1 locate his plate items, encourage him to feel for his items, and place his hands on his plate. The guidelines stated that client #1 was vision-limited. In addition, client #1 should have brightly-colored plates and bowls. Interview on 2/20/23 with Staff A revealed that client #1 was dependent on his Geri-Chair for all mobility and activities. Staff A stated that client #1 has limited vision. Interview on 2/21/23 with the Habilitation Specialist (HS) revealed that client #1 had regressed since last Spring and developed Alzheimer's. Interview on 2/21/23 with the facility nurse revealed that client #1 had regressed over the past year since he was hospitalized in April, 2022. The nurse stated that client #1 had increased sickness over the past year and depended on the Geri-Chair for mobility. Interview on 2/21/23 with the administrator revealed that client records should reflect updates for mobility and vision changes.	W 111		
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.	W 130		

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W 130	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to provide privacy to 2 of 4 audit clients (#1 and #4) during personal care and medication administration. The finding is: A. Observation in the facility on 2/20/23 at 3:50pm revealed Staff B and Staff C assisting client #1 to the hallway bathroom in his Geri-Chair. Staff B and Staff C stopped client #1's Geri-Chair in doorway, removed his clothing, and began to utilized wipes to remove a large amount of fecal matter. The door remained completely open, and client #1 was visible from the hallway. At 3:55pm, Staff C shut the bathroom door. At 3:58pm, Staff C exited the bathroom, leaving the door completely open. Staff B and Staff C utilized the lift and placed client #1 in the shower. The door remained completely open, and client #1 was visible from the hallway. At 4:03pm, the home manager (HM) entered the hallway and shut the door for privacy. Review on 2/20/23 of client #1's Individual Program Plan (IPP), dated 9/6/22, revealed client #1 is incontinent and dependent upon staff for toileting. In addition, client #1 is dependent upon staff to ensure privacy during all personal care. Interview on 2/20/23 with the HM revealed that the bathroom door should not have been open during personal care. Interview on 2/21/23 with Staff A revealed that doors should always be shut during personal care to ensure privacy. Interview on 2/21/23 with the administrator revealed that privacy should always be ensured	W 130		

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W 130	Continued From page 3 during personal care by closing doors and covering clients. The administrator stated that staff should not have had the door open. B. During medication administration observation 2/20/23 at 4:05pm, Staff B exited the medication room with client #4. Upon returning to the medication room, Staff B administered client #4's medication mixed with pudding with the door open to the public kitchen area. Interview on 2/21/23 with Staff F revealed that the door should always be shut during medication administration for privacy. Interview on 2/21/23 with the facility nurse revealed that the staff had been trained in privacy expectations. The nurse stated that doors should always be closed to ensure privacy as clients depend on staff for privacy. Interview on 2/21/23 with the administrator revealed that staff should have closed doors during medication administration as the expectation of the facility is to ensure privacy.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained to perform their duties efficiently while demonstrating respect and dignity during staff/client interaction. This affected 1 of 4 audit	W 189		

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W 189	Continued From page 4 clients (#1). The finding is: During afternoon observation in the home, client #1 had a toileting accident while in his Geri-Chair. At 3:50pm, Staff B and Staff C placed client #1's Geri-Chair in the bathroom door, removed his clothing, and began use wipes to clean him. At 3:52pm, Staff C turned to secure an additional glove, and Staff B asked, "Did you get s*** all over your hand?" Staff C then rolled client #1 in the Geri-Chair into the bathroom and shut the door. Staff B could be overheard from the hallway as she loudly talked about the toileting accident and repeated the word "s***". Interview on 2/21/23 with Staff A revealed that staff should not talk about toileting accidents or use profanity in front of clients. Interview on 2/21/23 with the administrator revealed that the facility would not tolerate staff disrespecting clients. The administrator stated that staff should not have discussed the toileting accident or used the slang in front of the client. In addition, the administrator stated that the facility would be taking action as verbal abuse.	W 189		
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:	W 382		

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W 382	Continued From page 5 Observations on 2/20/23 in the home medication administration area revealed Staff B leaving the medication area without locking medications in the cabinet. At 4:09pm, Staff B had a medication container on the counter with the surveyor holding one medication packet. Staff B exited the room to secure an item from the kitchen. At 4:21pm, Staff B had medication container on the counter and exited the room to go into the kitchen. Further observation on 2/20/23 revealed a sign on the medication room door stating "Do not leave the area while distributing medications. Make sure all medication cabinet doors are locked upon leaving the medication room." Interview on 2/21/23 with Staff F revealed that staff should never leave the medication room when administering medications. Interview on 2/21/23 with the facility's nurse revealed medications should never be left sitting unattended. The facility nurse stated that staff had been trained to be within arms reach of any opened medication and to never leave the area without locking the cabinet.	W 382		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. This potentially affected all clients residing in the home (#1 - #6). The findings are: Review on 2/20/23 of the facility's fire drill	W 440		

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W 440	Continued From page 6 evacuation reports revealed for the time period of January 2022 through January 2023, fire drills were not conducted for October 2022, November 2022, and December 2022. Interview with the administrator revealed the facility has started inservice for fire drill requirements with new staff. The administrator stated that she is aware drills were missed in October through December that should have been completed.	W 440		