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 04/27/2023

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 000	INITIAL COMMENTS A revisit was completed on April 27, 2023 for all previous deficiencies cited on February 21, 2023. All previously cited deficiencies were corrected. However, a deficiency was cited. The facility is not in compliance with all regulations surveyed.	W 000		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on records review and interviews, the facility failed to provide nursing services in accordance with the needs of client #1 relative to ensuring prescribed medical treatment was received. The finding is: Review on 4/27/23 of client #1's record revealed client #1 was admitted on 3/28/23 and released on 4/3/23 with prescribed, continued supplemental oxygen at night, as needed, including spot checks for oxygen. Further review of hospital notes revealed client #1 was again admitted on 4/15/23 to receive palliative care. Client #1 was released on 4/21/23 with prescribed two liters oxygen at night due to low saturations. Review on 4/27/23 of an inservice given by the facility nurse, dated 4/3/23, revealed client #1 would be placed on oxygen at 8:00pm via nasal cannula with oxygen concentrator set at two liters per minute. Education was provided to staff on how to read the oxygen concentrator and set two liters per minute, apply nasal cannula properly, and document if client #1 oxygen is either on or off every two hours. Further review of the inservice revealed one third shift staff having	W 331		

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

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W 331	Continued From page 1 completed inservice. Review on 4/27/23 of Oxygen Check Sheets dated 4/3/23 - 4/27/23 revealed staff were to check client #1's oxygen concentrate when in use to make sure level is maintained at two liters. Oxygen should only to to be used at bedtime. Checks by staff should occur every two hours from 8:00pm-6:00am. Should oxygen be taken off by client #1, staff should reapply and document. Further review revealed eight missing nights of documented oxygen checks by staff as follows: 4/4/23 4/5/23 4/6/23 4/14/23 4/21/23 4/22/23 4/23/23 4/24/23 Interview on 4/27/23 with Staff A revealed client #1 was presently in the hospital again. Staff A stated third shift staff had not been checking client #1's oxygen at night or documenting checks. Staff A stated client #1 had not been sleeping at night and had been sleeping throughout the daytime with no oxygen treatment. Staff A stated she had been telling administration that client #1's levels were not being checked and that he needed oxygen during the day. Interview on 4/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #1 had been in and out of the hospital for the past month. The QIDP stated client #1 first went to the hospital for seizures and was sent home with oxygen to use at night only. However, the QIDP	W 331		

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W 331	Continued From page 2	W 331		

stated client #1 had been sleeping during the day. The QIDP stated his oxygen had gone down on 4/25/23 when he attended the day program for a doctor visit, and he was taken to the hospital with low oxygen levels on 4/25/23.

Interview on 4/27/23 with the facility nurse revealed client #1 was hospitalized from 3/28/23-4/3/23 due to seizures. The facility nurse stated that on 4/3/23, client #1 returned to the home with prescribed oxygen and all staff were inserviced for oxygen care procedures. The facility nurse stated that client #1 reentered the hospital from 4/15/23-4/21/23 due to seizure difficulties and was briefly placed on a ventilator. The nurse stated client #1 reentered the hospital on 4/25/23 to present.

Further interview on 4/27/23 with the facility nurse revealed she had attempted to contact the hospital to have oxygen approved for daytime hours should client #1's level go down. The facility nurse stated the hospital did not give permission for daytime oxygen due to insurance reasons. When asked who was to monitor to ensure two-hour oxygen checks by staff were completed, the facility nurse stated "day shift staff should tell us if it was not filled out and I would have gone out to reinservice". The facility nurse stated no one had ever reported lack of documentation for client #1's oxygen levels or that third shift was not checking oxygen.

Interview on 4/27/23 with the facility administrator revealed client #1's health had declined, but he often "bounced back". The administrator stated the team was meeting to discuss plans for best providing care for client #1. The administrator stated monitoring of staff oxygen checks was

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W 331	Continued From page 3 necessary.	W 331		