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 _____	C 05/08/2023

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 complaint survey was conducted on 5/8/23 for intake #NC00201705. The allegation was not substantiated, however, one related deficiency was cited.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all allegations were thoroughly investigated and recommendations from the investigation were implemented. The findings are: A. Review on 5/8/23 of a facility investigation dated 3/1/23 revealed an allegation that client #3 "was struck on her hand in the laundry room and living room with a black serving spoon..." Additional review of the report noted various staff in the home were interviewed as well as client #3. Although at least three other cliients in the home are verbal and able to communicate their wants and needs, the report did not indicate other clients in the home were interviewed. Interview on 5/8/23 with the Administrator indicated clients in the home are usually interviewed whenever possible. B. Review on 5/8/23 of a facility investigation dated 3/1/23 revealed an allegation that client #3 "was struck on her hand in the laundry room and living room with a black serving spoon..." Additional review of the investigation indicated the allegation was not substantiated, however, recommendations were identified. The	W 154		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 154	Continued From page 1	W 154		

recommendations included, "All DSP at the Heath Home be in-service on RHA policy# (102.05) reporting Abuse, Neglect and Exploitation. To include any incident or accident regarding an RHA individual supported be reported immediately... all DSP's at Heath Home be re-trained in documenting all incidents in [Client #3] and all other individuals' behavior support plans appropriately...Increase interaction assessments to three for three consecutive months at Heath Home...Regarding some issues discussed in this investigation the Administrator and IDT members should review and discuss possible scheduling changes at this home...[Staff A] and [Staff C] should receive a corrective action for not reporting suspicions of abuse in a timely manner according to policy."

Further review of documentation provided revealed additional interaction assessments had been completed at the home over March '23 and April '23. No other documentation that the investigation recommendations had been completed was provided.

Interview on 5/8/23 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she had conducted staff training on Abuse, Neglect and Exploitation, however, no documentation could be located. The QIDP revealed she was not responsible for implementing any other recommendations from the investigation and was not sure if they had been completed.

Additional interview on 5/8/23 with the Administrator revealed documentation that the recommendations from the investigation had been implemented could not be located.