| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G009 | A. BUILDING _____ B. WING _____ | 02/27/2024 |

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| **WALNUT CREEK** | **5709 US 70 EAST GOLDSBORO, NC 27534** |

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| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>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.<br>This STANDARD is not met as evidenced by:<br>Based on observations, documentation and interviews, the facility failed to ensure staff were sufficiently trained in the usage of cell phones, wheelchair seatbelts and medication administration for 5 of 11 audit clients (#2, #17, #22, #33, and #36). The findings are:<br><br>A. During morning observations in the home on 2/27/24 at 6:53am, client #2's seatbelt on his wheelchair was observed to be unhooked and hanging down. Client #2's wheelchair seatbelt remained unhooked until 7:21am, when Nurse A went over to client #2 and re-hooked his wheelchair seatbelt.<br><br>During an immediate interview Nurse A stated client #2's wheelchair seatbelt should always be hooked.<br><br>During an immediate interview Staff B revealed client #2's wheelchair seatbelt should always be hooked. Further interview revealed it was unknown who got client #2 up in his wheelchair.<br><br>During an interview on 2/27/24, the Habilitation Specialist stated third shift is responsible for getting client #2 into his wheelchair in the morning.<br><br>During an interview on 2/27/24, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2's wheelchair seatbelt should | W 189 | | |

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

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always be hooked when he is sitting in his wheelchair.

B. During morning observations in the home on 2/27/24 at 6:54am, Staff C was observed to be strolling on their cellphone. Staff C was on their cellphone for forty-five seconds. Further observations revealed there were six clients up and dressed in the day room where Staff C was sitting.

During an interview on 2/27/24, Staff C stated she was looking at her work schedule. During the interview Staff C was unable to explain why they should not have been on their cellphone while on duty.

During morning observations in the home on 2/27/24 at 6:56am, Nurse C was observed to be looking at a video on their cellphone for one three minutes while sitting in the kitchen. Further observations revealed there were six clients up and dressed in the dayroom. When asked should they be on their cellphone while clients are up, Nurse C stated that she should not have been. During further interview Nurse C stated she was on her break; but was still responsible for the clients if an emergency was to occur.

Review on 2/27/24 of the facility's cellphone policy (10/1/17) revealed, "While in the workplace during an employee's working time, employees are expected to focus on work ad should not excessively engage in personal use of any personal mobile device in the workplace, including but not limited to: engaging in excessive personal conversations, excessively checking personal e-mail, excessively sending or receiving text messages, playing games, listening

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| W 189 | Continued From page 2<br>to audio, watching video content, surfing the Internet and/or visiting social media sites. Personal mobile devices should be stored in the employee's desk drawer, briefcase, backpack, purse or vehicle during working time...."<br><br>During an interview on 2/27/24, the Director of Nursing (DON) stated cellphones should not be used while staff is on duty.<br><br>During an interview on 2/27/24, the QIDP confirmed cellphones are not allowed to be used while staff are on duty.<br><br>C. During medication administration on 2/26/24 at 5:33pm, Nurse A was observed giving client #17 their medications. At no time was client #17 informed about what medications they were consuming.<br><br>During medication administration on 2/27/24 at 7:34am, Nurse A was observed giving client #2 their medications. At no time was client #2 informed about what medications they were consuming.<br><br>During medication administration on 2/26/24 at 4:30pm, nurse B was observed giving client #22 their medications. At no time was client #22 informed about what medications he was consuming.<br><br>During medication administration on 2/26/24 at 4:50pm, nurse B was observed giving client #23 their medications. At no time was client #23 | W 189 | | |

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| W 189 | Continued From page 3<br>informed about what medications he was consuming.<br><br>During medication administration on 2/27/24 at 7:30am, nurse B was observed giving client #36 their medications. At no time was client #36 informed about what medications he was consuming.<br><br>During an interview on 2/27/24, the DON revealed the nursing staff should be informing the clients to what type of medications they are consuming. | W 189 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 1 of 11 audit clients (#21) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive equipment and hearing aids. The findings are:<br><br>A. During observations in the home on 2/26/24 from 3:25pm until 5:45pm, client #21 was | W 249 | | |

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| W 249 | Continued From page 4<br>observed not wearing her hearing aids while sitting in the dayroom. At no time did staff ask her if she wanted to wear her hearing aids.<br><br>During observations in the home on 2/27/24 from 5:53am until 7:12am, client #21 was observed not wearing her hearing aids, while sitting in the dayroom. At no time did staff ask her if she wanted to wear her hearing aids.<br><br>Review on 2/26/24 of client #21's IPP dated 4/11/23 revealed she wears hearing aids during her awake hours.<br><br>During an interview on 2/27/24, the Qualified Intellectual Disabilities Professional (QIDP) stated client #21 should be wearing her hearing aids during her awake hours.<br><br>B. During dinner observations in the home on 2/26/24 at 4:59pm, client #21 was observed not using her dycem mat while she was eating. At no time was client #21's dycem mat used.<br><br>During breakfast observations in the home on 2/27/24 at 7:45am, client #21 was observed not using her dycem mat while she was eating. At no time was client #21's dycem mat used.<br><br>Review on 2/26/24 of client #21's IPP dated 4/11/23 stated she uses a dycem mat for all meals.<br><br>During an interview on 2/27/24, the QIDP stated client #21 should be using her dycem mat whenever she is eating. | W 249 | | |
| W 260 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(2) | W 260 | | |

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| W 260 | Continued From page 5<br><br>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the individual program plan (IPP) for 1 of 11 audit clients (#27) was revised at least annually. The finding is:<br><br>Review on 2/26/24 of client #27's record revealed an IPP dated 1/19/22. No current IPP could be located.<br><br>Interview on 2/27/24 with the qualified intellectual disabilities professional (QIDP) confirmed no current IPP could be located for client #27. | W 260 | | |
| W 454 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially 3 of 11 audit clients (#1, #14 and #22). The findings are:<br><br>A. During observations on 2/26/24 at 4:22pm, Nurse A and Staff D moved two portable mobile devices from clients #1 and #14 and switched them. Both clients #1 and #14 had the toys that were attached to the mobile devices in their mouths prior to them being switched. Further | W 454 | | |

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| W 454 | Continued From page 6<br>observations revealed neither mobile device was disinfected prior to being switched.<br><br>During an interview on 2/27/24, Nurse A stated the mobile devices should have been disinfected prior to them being switched between clients #1 and #14.<br><br>During an interview on 2/27/24, the Qualified Intellectual Disabilities Professional (QIDP) stated the two mobile devices should have been cleaned prior to being switched between clients #1 and #14.<br><br>B. During observations on 2/26/24 at 5:30pm, staff A opened a condiment packet by putting it in his mouth and opening with teeth then putting the condiment on client #22's food. Client #22 then asked for another packet and staff A opened the condiment packet with his teeth and again, put the contents of the packet on client #22's food.<br><br>During an interview on 2/27/24, the QIDP confirmed staff should not open any condiment packets with their mouth. | W 454 | | |