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

PRINTED: 05/09/2023
FORM APPROVED
OMB NO. 0938-0391

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 clients 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	The Investigator and Administrator will ensure that all residents are interviewed during investigations. This will be monitored by completing the investigation checklist report to ensure all elements of the investigations are completed. QPs and the Administrator will ensure that all recommendations for investigations are completed. This will be monitored by completing and reviewing the investigation checklist reports for each investigation initiated at the unit. The administrator will be re-in-servicing QPs (investigators) on completing investigations recommendations. QA Specialist will review all completed investigations at the Benson Unit to ensure that all recommendations are completed within 10 days of the completed investigation. QP will ensure all allegations are thoroughly investigated and recommendations from the investigation are implemented in a timely manner.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nashed Blue
TITLE: administrator
(X6) DATE: 5/22/23

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 154	Continued From page 1 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 DSPs 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.	W 154		