STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

(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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services to support the achievement of the objectives identified in the individual program plan. This affected 4 of 4 audit clients (#1, #2, #5 and #6). The findings are: Observation on 6/24/25 from 2:53pm - 4:45pm revealed, clients #1, #2, #5 and #6 were in the living room with the tv on however they were not watching it. The clients were not prompted to engage in any meaningful activities. Client #1 maneuvered around in his wheelchair frequently back and forth between the kitchen and the living room. Client #2 stayed in her bedroom room the entire time. Staff A and staff C checked on her frequently however client #2 was not encouraged to join the other clients or participate in any activities. Client #5 walked back and forth between his bedroom, the living room and the kitchen. Client #5 did not participate in any meal preparation activities or any other activities in the home. Client #6 sat on the sofa during the entire	W 249		

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
	34G329	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

(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 249	Continued From page 1 observation. At one point, staff gave her paper and writing utensils but client did not seem interested and shortly thereafter she put the paper down. At no time did staff offer choice of activities or engage clients in objective training. Observation on 6/25/25 from 6:29am - 7:30am revealed, client #1 was sitting in his bedroom. Client #2 was pacing back and forth between the bedroom and kitchen, while staff D swept the floor. Client #5 was in his bedroom but later walked out and paced back and forth between the kitchen and the living room. Client #6 was asleep on the couch. Staff did not encourage any meaningful activities or objective training for any clients during this time. Staff F sat on the couch and called client #6's name and asked her to wake up however she did not. Staff D cooked the entire breakfast with very little client assistance. Client #1 did assist with cracking eggs for breakfast however once completed, he began to pace throughout the house again. Interview on 6/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that staff should be providing active treatment and clients should not just be sitting around, not engaging in activities. She understands that clients may want downtime after returning home from the day program or community outings, however, it is the expectation that clients participate in activities and assist in meal prep activities.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team,	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

(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 340	Continued From page 2	W 340		

appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.
This STANDARD is not met as evidenced by:
Based on observations, record review and interview, nursing services failed to ensure staff were sufficiently trained in the area medication administration. This affected 3 of 4 audit clients (#1, #2, and #5). The findings are:

A. Observations of medication administration on 6/24/25 at 4:00pm revealed staff C informed client #1 it was time to take his medicine while he was sitting at the kitchen table having a snack. Staff C prepared client #1's Felbamate 600mg (1 tablet four times daily). It was not observed that staff C checked the electronic medication administration record (EMAR) prior to the medication pass. While attempting to administer the medication, Client #1 began screaming and saying no. He then started making spitting sounds. Staff C attempted to redirect client by stating no spitting, while still trying to administer his medication. Staff C informed the Surveyor that she was going to take client #1 into his bedroom to give him privacy because he does not like to take his medications in front of others.

Continued observation on 6/24/25 revealed while in the bedroom, client #1 continued to say no and make spitting sounds. Staff C redirected the behavior and then asked staff A if she could assist with administering client #1's medication. Staff A went into client #1's bedroom to assist. She then walked to the medication room and placed his medication in the room. Staff A locked the med room door and returned to client #1's bedroom. Staff A stated she was going to talk to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

(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 340	Continued From page 3	W 340		

client #1 to try to get him to calm down. Once calm, staff A retrieved the medication from the med room and took it back into client #1's bedroom. A few moments later, she walked out of his bedroom and informed staff C, he took the medication. Staff C was walking from the living room back toward the med room when staff A notified her. Staff C logged into the computer located in the kitchen and signed her initials in the EMAR as administering client #1's the medication.

Review on 6/25/25 client #1's Individual Program Plan (IPP) dated 8/21/24 revealed he does not like for people to watch him while he takes his medication. He cannot self-medicate but should be encouraged to participate as tolerated.

Interview on 6/24/25 with staff C revealed she was trained to check the name of the medication to ensure it is correct and the correct time. She further stated staff should administer the medication to the client and then sign the bubble pack and the EMAR. Staff C confirmed she signed off on administering client #1's 4:00pm dosage of Felbamate on 6/24/25.

Interview on 6/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that staff should not sign off as administering the clients medication if they were not the one to administer it. She also confirmed the staff should review the MAR during administration to ensure they have the right client, right medication and right time.

B. Observation on 4/25/25 at 7:00am revealed staff B informed client #2 that it was time to receive her medication and asked client #2 to pull

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

(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 340	Continued From page 4	W 340		

her medication bin from the shelf. Client #2 grabbed her bin and placed in on the counter. Staff B punched out all medications and placed them in a cup, without assistance from client #2. Staff handed client #2 the medication cup and client #2 took the medications. Staff B did not inform client #2 of the medications she was receiving or the reason why.

Review on 4/25/25 of client #2's IPP dated 12/14/24 revealed she is unable to administer her own medications. It is staff responsibility to administer her medication. She should be encouraged to participate in the process as tolerated.

Observation on 4/25/25 at 7:36am revealed client #5 pulled his medication bin from the shelf. Staff B popped out all of client #5's medication without any assistance from client #5 and placed them into a cup. Staff handed client #5 the cup and he ingested his medication. Staff did not inform client #5 of the medication he was receiving or the reason why.

Review on 4/25/25 of client #5's IPP dated 3/27/25 revealed a diagnoses included Mild-Moderate Intellectual Disability Disorder (IDD). He is able to understand the medication administration process, but unable to administer medication on time, without supervision.

Interview on 4/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should participate as much as possible in the medication administration process. Client #5 is able to participate more during med pass. Staff should at least ask the client to participate. Staff should also educate clients on the medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G329	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY ROAD	1503 KIMBERLY ROAD NEW BERN, NC 28562

(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 340	Continued From page 5 they are receiving.	W 340		