

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2024
NAME OF PROVIDER OR SUPPLIER O'Berry Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Old Smithfield Road Goldsboro, NC 27533	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41387</p> <p>Based on observation, record review, Responsible Party interview, staff interviews and a Physician interview, the facility failed to protect Resident #1 from neglect by not implementing effective interventions to prevent a resident with a known diagnosis of PICA disorder (a mental health condition where a person compulsively eats non-food items that are harmful or toxic) from repeated incidents of accessing and ingesting medical examination gloves. On 2/21/2024, Resident #1 vomited two medical examination gloves. On 2/24/2024, a dime size object resembling a part of a medical examination glove was observed in Resident #1's enteral feeding (nutrition delivered through a tube placed into the stomach or small intestine) residual (enteral feeding not digested from the stomach). On 3/24/2024, Resident #1 vomited two medical examination gloves. On 4/5/2024, Resident #1 was found lying in bed with a medical examination glove in emesis under her pillow. The ingestion and vomiting of examination gloves created a high likelihood of serious harm such as a blockage of Resident #1's airway, choking, and aspiration (when something swallowed or vomited enters the airway or lungs). This deficient practice was for 1 of 3 residents reviewed for neglect (Resident #1).</p> <p>Immediate jeopardy began on 2/21/2024 when the facility neglected to implement effective interventions to prevent Resident #1 from accessing and ingesting medical examination gloves. Immediate jeopardy was removed on 4/20/2024 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower level and severity of E (no harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put in place were effective.</p> <p>Findings included:</p> <p>This tag is cross referenced to:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>F689: Based on observation, record review, Responsible Party interview, staff interviews and a Physician interview, the facility failed to provide supervision to prevent a resident with a known diagnosis of PICA disorder (a mental health condition where a person compulsively eats non-food items that are harmful or toxic) from engaging in PICA behaviors. On 2/21/2024, Resident #1 vomited two medical examination gloves. On 2/24/2024 a dime size object resembling a part of a medical examination glove was observed in Resident #1's enteral feeding (nutrition delivered through a tube placed into the stomach or small intestine) residual (enteral feeding not digested from the stomach area). On 3/24/2024, Resident #1 vomited two medical examination gloves. On 4/5/2024 Resident #1 was found lying in bed with a medical examination glove in vomit under the edge of her pillow. The ingestion and vomiting of examination gloves created a high likelihood of serious harm such as a blockage of the resident's airway, choking, and aspiration (when something swallowed or vomited enters the airway or lungs). This deficient practice was for 1of 3 residents reviewed for accidents (Resident #1).</p> <p>In an interview with Advocate #1 on 4/17/2024 at 4:00 p.m., she explained she advocated for resident's rights and her investigation consisted of ensuring Resident #1's rights were not infringed upon, and abuse and neglect of care had not occurred. She stated she substantiated neglect in her investigations of Resident #1's incidents for PICA behaviors on 2/21/2024, 3/24/2024 and 4/5/2024. She explained the fact that Resident #1 swallowing gloves endangered her life, the interventions for PICA behaviors were not working to prevent Resident #1's ingestion of gloves and staff failed to ensure Resident #1's safety when a glove was found in the bed on 4/5/2024 that Resident #1 could have ingested and endangered her life. She explained since Resident #1 didn't have the behavior to search for gloves, the staff were leaving gloves where Resident #1 could find and ingest. She explained she did not investigate the incident on 2/24/2024 because Unit Nurse Manager #1 thought the piece of glove in the enteral residual came from a pinched/torn glove when conducting procedures with Resident #1's gastrostomy tube.</p> <p>The Administrator was notified of immediate jeopardy on 4/16/2024 at 12:20 PM.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the non-compliance.</p> <p>On 2/21/2024, while in the medication room, Resident #1 was observed by Nurse #1 gagging and vomiting two medical examination gloves into her lap. Resident #1 was assessed by Nurse #1 and Medical Provider. There were no signs of distress after vomiting and no further concerns. Per the facility's Policy ADM 09-25 our facility resident advocacy department and management were contacted.</p> <p>On 2/21/2024, the Division of Health Service Regulation (DHSR) initial report was completed and faxed.</p> <p>No Adult Protective Services and Law Enforcement notifications were made due to abuse not being suspected. Resident Guardian was notified by the charge nurse on duty.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On, 2/21/2024, the facility Resident Advocate, Management Investigator, and Unit Nurse Manager initiated an investigation. They interviewed 5 Certified Nursing Assistants (CNA's) and 2 Registered Nurses (RN's). The results of the investigation were inconclusive. No staff acknowledges leaving gloves in proximity of the resident, we were not able to determine a trigger event, and we could not conclude with certainty when the gloves were swallowed.</p> <p>On 2/23/2024 Interdisciplinary Team (Occupational Therapy, Management Investigator, Speech Language Pathologist, Recreation Therapy Assistant, Risk Manager, Facility Advocate, Performance Improvement Specialist, Non-Certified Unit Manager, Behavior Specialist, MDS Nurse) meeting was held. The team agreed to place Resident #1 on enhanced supervision defined as visual monitoring while in wheelchair and a special care sheet was implemented which is written instructions for level of supervision. Resident #1 was placed on 1:1 coverage when in wheelchair not in group setting. Sufficient staffing for this unit is currently identified at 4 nurse aids for each 12 residents during waking hours. There are staff assigned to visual monitoring at the beginning of each shift.</p> <p>On 02/24/2024, Floor Shift Nurse Supervisors ensured staff's understanding of the changes in resident supervision requirements and the importance of maintaining enhanced supervision with her due to her PICA behavior as indicated by the Special Care Sheet during shift change briefing through a question-and-answer session. The Unit Nurse Manager followed-up to ensure understanding of the Special Care Sheet on 2/24/24 by walking rounds and conversation with cluster 2 staff.</p> <p>On 2/24/2024, Nurse #2 observed an approximately dime size object resembling a part of a medical examination glove in the residual enteral feeding (enteral feeding not digested from the stomach area). It was determined by the medical provider to be part of the previous ingestion.</p> <p>On 3/24/2024 at 10:45a.m. while staff was brushing resident's hair in the dayroom, Resident #1 gagged and coughed up two gloves. Resident was assessed by the Floor Shift Nurse Supervisor. Resident was placed on 1:1 for 24 hours by Floor Shift Nurse Supervisor until additional safety measures could be put in place. Per the facility's Policy ADM 09-25 our facility resident advocacy department and management was contacted.</p> <p>On 3/24/2024, the Division of Health Service Regulation (DHSR) initial report was completed and faxed.</p> <p>No Adult Protective Services and Law Enforcement notifications were made due to abuse not being suspected. Resident Guardian was notified by the charge nurse on duty.</p> <p>On, 3/24/2024, the facility Resident Advocate, Management Investigator and Unit Nurse Manager initiated an investigation. They interviewed 4 CNA's, and 1 Floor Shift Nurse Supervisor, and reviewed video footage. The results of the investigation once again inconclusive. No staff acknowledges leaving gloves in proximity of the resident, we were not able to determine a trigger event, and we could not conclude with certainty when the gloves were swallowed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 3/24/2024 In person, in-service of Unit 2-1 staff (the unit Resident #1 resided in) on resident's change in supervision as related to PICA was initiated by Floor Shift Nurse Supervisor. Supervision was increased for Resident #1 to 1:1 for 24 hours until an area assessment could be complete. Additionally, Resident #1's supervision level was changed upon the completion of the assessment to visual supervision while in wheelchair, 15 minute checks while awake not in wheelchair, 30 minute checks while sleeping. A monitoring sheet was to be completed anytime, not in group setting.</p> <p>On 4/05/2024, a glove was found in Resident #1's bed between two pillows. The resident's bed had sputum and vomit in the bed, but the glove was found separate from the debris. Resident was assessed by medical provider, and the area was surveyed for additional inedible debris by the Minimum Data Set (MDS) Coordinator. Per Policy AM 09-25 the Facility Advocacy and management was contacted. Facility Advocacy determine that this was not an advocacy issue based on the glove being found between two pillows with no vomit on the second pillow. Since the pillows were stacked and vomit was only found on the top pillow, it was the conclusion of the facility advocate and management that the glove found had not yet been ingested. Based on the investigation findings, the Division of Health Service Regulation (DHSR) initial report was not completed due to the findings that this was a near miss event.</p> <p>On 04/05/2024 Management investigation initiated by the Unit Consultant and Unit Nurse Manager for a Root Cause Analysis and Systems improvements. The root cause analysis determined that despite education, Resident #1 still had nonedible objects in proximity. The most likely cause would be inadvertently dropping gloves or the resident pulling them out of staff pockets while staff were occupied doing resident care such as bathing, toileting, or repositioning.</p> <p>Resident #1 is listed as one of 13 residents with documented and care planned historical diagnosis of PICA. Due to behavior consistent with individual medical diagnosis, no other residents are actively engaging in PICA behaviors. All known behaviors are reviewed as part of the annual Minimum Data Set (MDS) assessments, care plans meetings quarterly and as part of our monthly reviews of the residents with the interdisciplinary teams including of psychology, pharmacy, dieticians, medical providers, social workers, and other members of the care team.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring, and when the action will be complete.</p> <p>On 2/21/2024, staff assigned to Unit 2-1 (the unit where Resident #1 resides) were in-serviced on PICA and Positive behavior supports as trained in Person Centered Care including redirection when seeking behavior (residents with compulsive behaviors tend to seek the compulsions) is observed. This was completed by the Unit Nurse Manager and the Floor Shift Nurse Supervisors in Building 2. This training was completed with direct care providers who work with Resident #1 in Unit 2-1 and staff who provide coverage from other units in Building 2.</p> <p>On 3/25/2024, a unit assessment was completed to determine possible sources of gloves by the Unit Nurse Manager in resident's unit (Unit 2-1) as it is not likely the resident would be moved to a different unit. The source of the gloves was not determined but the following interventions were put in place. If the resident would be relocated, the incoming Unit Nurse Manager would be responsible to ensure current interventions will be completed as part of the incoming process. The Nursing Home Administrator informed the Unit Nurse Managers present on campus of this responsibility 4/19/2024. Unit Nurse Managers not informed of this responsibility will be informed on the first day returning to work at the start of shift during morning briefing by the Nursing Home Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Removed gloves from tube feeding cart. Completed by the Unit Nurse Manager 03/24/2024 - Removed all trash cans without lids from patient care areas. Completed by the Unit Nurse Manager. 03/24/2024 - Ensured all trash cans in patient care area had lids. Completed by the Unit Nurse Manager. 03/24/2024 - Raised glove holder in medication room to prevent access completed by Unit Nurse Manager and maintenance. Work order was submitted on 3/25/24 completed on 3/28/24. <p>On 3/26/24, the Floor Shift Nurse Supervisor initiated an in person in-service at shift change for all Unit 2-1 staff on the following. This will continue with roster at shift change until all staff have been in-serviced. This roster will be turned in to the facility compliance officer as part of the plan of correction weekly until all staff have been training or until new measures are put in place.</p> <ul style="list-style-type: none"> - When providing care, ensure trash can is used and not to place trash in bags on the floor or bed. - Keep bedside free of gloves and other objects resident may ingest to be monitored by direct care staff, environmental services, and supervisors. - Change resident's supervision to Enhanced supervision to when resident is in wheelchair, she is visually supervised at all times and 15 minutes checks when in her bedroom, in her recliner with 30 minute checks when asleep. Monitoring of enhanced supervision will be conducted by the Home Life Support Assistance/charge person. On-going - Monitoring for compliance with all expectations to be done daily by Floor Shift Nurse Supervisor, Unit Nurse Manager, Nurse Aide II, Non-Certified Unit Manager by visual monitoring and paperwork review. On-going - Training of all new staff on care plans prior to working with residents with pica history will be completed by their assigned Nurse Aide II mentor and followed-up by their Floor Shift Nurse Supervisor. Rosters will be maintained on the unit. - [NAME] data to be discussed at QAA meetings quarterly and more frequently as determined by trends or frequency by the Quality Data Managers. First Meeting on 4/17/24. <p>On 04/05/2024, in person in-servicing was initiated by the Risk Management Department and the facility advocate. This training was presented to all staff in Building 2-1 inclusive of ancillary staff such as housekeeping assigned to the area. This in-service was completed to all Unit 1 assigned staff on:</p> <ul style="list-style-type: none"> - Proper use of gloves for patient care - Not wearing gloves down the halls when not providing patient care <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Not keeping extra gloves in their pockets - When providing care for resident, two people should be present when providing care and to ensure proper disposal of gloves. - Document on the flow sheet proper disposal of gloves and that two people were present. - While resident is in common areas, the area should be checked for inedible objects Resident #1 may be able to consume and documented by the charge Nurse Aide every thirty minutes. - While resident is the bedroom, the resident bedroom should be checked for inedible objects Resident #1 may be able to consume by assigned staff and documented per supervision guidelines currently established as q15 (every 15 minutes) awake and q30 asleep. <p>On 4/18/2024, the facility compliance office initiated a review by the interdisciplinary team that will review Care Plans for all (13) residents on campus who has a history of or a diagnosis of PICA to ensure appropriateness of interventions/strategies and the effectiveness of them. This will be done by 4/19/2024. The non-certified home manager will coordinate the meeting and the results will be documented in the medical records and psychology will up-date their assessments if changes are made. PICA behaviors will be monitored by Psychologist quarterly and more often as determined by changes to include an increase in behaviors being monitored. Direct Care staff will continue to input data into the Kiosk (electronic data collection system) regarding behaviors being exhibited based on the strategies determined by the team to be monitored. This process for Kiosk data input is already in place. The psychologist will collect and analyze the data to determine Behavior Strategies if needed, and Behavior Strategies will be reviewed by the clinical review team quarterly as assigned and more often based on need.</p> <p>Once PICA strategies are validated, the non-certified unit managers and the Unit Nurse Managers will conduct in-person in-services to educate direct care staff on understanding where to locate the PICA strategies of all residents assigned to their unit by 4/19/2024. All staff will be made aware of the location of the supervision forms containing PICA information and the requirement to carry the form on their person for the entirety of their shift. The forms for each unit will be located in a predetermined location for ease of staff will be picked up at the beginning of each shift and placed in an appropriate container for shredding at the end of shift. Any staff not receiving training by 4/19/2024 will be required to be training by the manager prior to the beginning of the next shift. The same PICA training will be presented, in person, by workforce development Nurse Educators for future New Employee Orientation. The Workforce development office was made aware of this requirement by the Compliance Officer on 04/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 4/17/2024, in-person, campus-wide, education was initiated on PICA behaviors, and potential side effects to include death. This education will be provided by Managers with rosters to be completed and signed acknowledging the training had occurred and opportunities had been provided to ask questions. Supervisors will receive a list of all residents with PICA behaviors. This will be completed by 4/19/2024 with rosters turned in to managers to ensure all staff are trained. Once completed, rosters will be turned in to the Compliance Officer by 4/19/2024. Any staff not receiving training by 4/19/2024 will be required to be trained by the manager prior to the beginning of the next shift. The same PICA training will be presented, in person, for future New Employee Orientation by workforce development Nurse Educators for future New Employee Orientation. The Workforce development office was made aware of this requirement by the Compliance Officer on 04/19/2024.</p> <p>On 4/19/2024, in-person, campus-wide, education was initiated on the importance of compliance, with all prescribed treatment to include interventions, and a failure to being a negligent act. This education will be provided by Managers with rosters to be completed and signed acknowledging the training had occurred and opportunities had been provided to ask questions. This will be completed by 4/19/2024 with rosters turned in to the Compliance Officer to ensure all staff are trained. Any staff not receiving training by 4/19/2024 will be required to be trained by the manager prior to the beginning of the next shift. The same Neglect training will be presented, in person, for future New Employee Orientation. The Workforce development office was made aware of this requirement by the Compliance Officer on 04/19/2024.</p> <p>Alleged date of immediate jeopardy removal: 4/20/2024</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Onsite validation of the immediate jeopardy removal plan was completed on 4/21/2024. Review was completed of in-service logs dated 2/21/2024 showed staff in Unit 2-1 were provided training on PICA behaviors, Resident #1's supervision level, removing objects from arms reach she can swallow, and completing a room sweep. The training was provided by the Unit Manager to staff who provided direct care to Resident #1. Interview randomly completed with a Unit Manager indicated she had received training she was responsible for communicating resident's needs to new supervisors, she removed gloves from tube feeding carts, removed all trash cans without lids from patient care areas, ensured all trash cans in patient care areas had lids, and raised a glove holder in the medication room. Record review showed the glove holder in the medication room was raised on 3/28/2024. Observations completed on 4/21/2024 showed the trash cans in Resident #1's living area had lids, there were no gloves within reach around the unit to include Resident #1's room and there were no gloves observed on the tube feeding cart. Review completed of an in-service log dated 3/26/2024 showed staff in Unit 2-1 were provided training on not placing trash bags on floor or bed when providing care, keep bedside free of gloves and other nonedible items, Resident #1 is to be supervised at all times, 15 minutes checks when in bedroom and 30 minutes checks when she's asleep. Review was completed of in-service logs dated 4/5/2024 showed staff in Unit 2-1 were provided training on only wearing gloves when providing resident care, not keeping extra gloves in their pockets, two staff were required to be present providing care to ensure proper disposal of gloves, document on flow sheet proper disposal of gloves and two people present, check the area around Resident #1 for inedible objects and document every thirty minutes, check Resident #1's bedroom for inedible objects and document every 15 minutes when awake and thirty minutes when sleeping. Review of Resident #1's enhanced monitoring was randomly checked and was completed by staff. Through interviews shift floor nurse supervisors, unit nurse managers, nurse aide II were aware they were responsible for ensuring Resident #1's monitoring sheets were completed. Record review showed the Quality Assurance and Performance Improvement (QAPI) committee had a meeting on 4/17/24 and discussed Resident #1. A review was completed of the audited list of care plans reviewed and a random selection of residents was made to ensure meetings were conducted to discuss interventions/strategies. Review of randomly selected in-service logs dated 4/19/2024 showed the Unit Nurse Manager or Non-Certified Unit Manager had in-serviced staff in their unit about the interventions in place for residents with a diagnosis of PICA. Staff were able to show where the supervision forms were stored, and staff had a current form on their person. Review of completed campus wide in-services dated 4/19/2024 showed staff received training about PICA behaviors, potential side effects of PICA behaviors, and neglect of residents. Randomly selected names from different units and shifts were selected from each in-service and were interviewed to verified they had received training. The immediate jeopardy removal date of 4/20/24 was validated.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41387</p> <p>Based on record review and staff interviews, the facility failed to report allegations of neglect to the state agency within the required timeframe. Additionally, the facility failed to report allegations of neglect to Adult Protective Services (APS) and law enforcement. This deficient practice was for 1 of 3 resident reviewed for neglect.</p> <p>Finding included:</p> <p>a. A review of the Initial Allegation Report for an allegation of neglect submitted on 2/22/2024 at 2:37 p.m. indicated the facility became aware of an incident on 2/21/2024 at 10:10 a.m. for Resident #1. The initial report did not indicate local law enforcement or APS were notified.</p> <p>The Investigation Report completed on 2/29/2023 by for the 2/21/24 incident Resident #1 did not indicate local law enforcement or APS were notified.</p> <p>In a phone interview with the Administrator and Deputy Director of Standards on 4/19/2024 at 4:54 p.m., they stated the incident on 2/21/2024 was not reported to the local APS and police department because those agencies were only notified if the facility was not able to provide Resident #1 protection. They explained that generally neglect was not reported to APS and the police department unless there was a suspicion of a crime.</p> <p>b. A review of a facility event report dated 2/24/2024 at 2:00 a.m. indicated when checking residuals (enteral feeding not digested from the stomach area) at 02:00 a.m. a small part of a grey glove was found in the gastric fluid and a coffee ground substance.</p> <p>During a complaint investigation and revisit survey, the Administrator was officially notified of neglect on 4/16/2024 at 12:20 p.m. related to the 2/24/2024 incident for Resident #1. An immediate jeopardy template was provided to the Administrator.</p> <p>The facility did not have an initial report or an investigation report that was sent to the state agency reporting the 2/24/2024 incident regarding the small glove fragment observed in the enteral residual for Resident #1. Additionally, there was no documentation of notification to APS or the local police department.</p> <p>In an interview on 4/17/2024 at 4:30 p.m., the Director of Nursing (DON) verified the 2/24/2024 incident was not reported to the state agency because it was reported that the small piece of glove could have been from the 2/21/2024 incident or torn from a nurse's glove when caring for Resident #1's gastrostomy tube.</p> <p>In a phone interview with the Administrator and Deputy Director of Standards on 4/19/2024 at 4:54 p.m., they stated the incident on 2/24/2024 was not reported to the local APS and police department because those agencies were only notified if the facility was not able to provide Resident #1 protection. They explained that generally neglect was not reported to APS and the police department unless there was a suspicion of a crime.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER O'Berry Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Old Smithfield Road Goldsboro, NC 27533	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. A review of the Initial Allegation Report for an allegation of neglect submitted on 3/25/2024 with no fax information for the time and the revised Initial Allegation Report submitted on 3/26/2024 at 11:29 a.m. indicated the facility became aware of an incident on 3/24/2024 at 10:25a.m. for Resident #1. The initial report and revised initial report did not indicate local law enforcement or APS were notified.</p> <p>The Investigation Report submitted on 3/28/2023 for the 3/24/24 incident for Resident #1 did not indicate local law enforcement or APS were notified.</p> <p>In a phone interview with the Administrator and Deputy Director of Standards on 4/19/2024 at 4:54 p.m., they stated the incident on 3/24/2024 was not reported to the local APS and police department because those agencies were only notified if the facility was not able to provide Resident #1 protection. They explained that generally neglect was not reported to APS and the police department unless there was a suspicion of a crime.</p> <p>d. A core (interdisciplinary) meeting report dated 4/5/2024 recorded on the morning of 4/5/2024 at 7:50 a.m., Floor Shift Supervisor #1 was called to Resident #1's room where the resident was lying in the bed with vomit on the bed and the pillow, and there was an intact gray glove in the vomit.</p> <p>During a complaint investigation and revisit survey, the Administrator was officially notified of neglect on 4/16/24 at 12:20 p.m. related to the 4/5/24 incident for Resident #1. An immediate jeopardy template was provided to the Administrator.</p> <p>The facility did not have an initial allegation report nor an investigation report sent to the state agency related to the 4/5/2024 incident for Resident #1. Additionally, there was no documentation of notification to APS or the local police department.</p> <p>In an interview with the Director of Nursing (DON) on 4/17/2024 at 4:35 p.m., he verified the 4/5/2024 incident was not reported to the state agency because it was not reported to him that Resident #1 ingested the glove located on Resident #1's bed.</p> <p>In a phone interview with the Administrator and Deputy Director of Standards on 4/19/2024 at 4:54 p.m., they explained that generally neglect was not reported to APS and the police department unless there was a suspicion of a crime.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387</p> <p>Based on observation, record review, Responsible Party interview, staff interviews and a Physician interview, the facility failed to provide supervision to prevent a resident with a known diagnosis of PICA disorder (a mental health condition where a person compulsively eats non-food items that are harmful or toxic) from engaging in PICA behaviors. On 2/21/2024, Resident #1 vomited two medical examination gloves. On 2/24/2024 a dime size object resembling a part of a medical examination glove was observed in Resident #1's enteral feeding (nutrition delivered through a tube placed into the stomach or small intestine) residual (enteral feeding not digested from the stomach area). On 3/24/2024, Resident #1 vomited two medical examination gloves. On 4/5/2024 Resident #1 was found lying in bed with a medical examination glove in vomit under the edge of her pillow. The ingestion and vomiting of examination gloves created a high likelihood of serious harm such as a blockage of the resident's airway, choking, and aspiration (when something swallowed or vomited enters the airway or lungs). This deficient practice was for 1of 3 residents reviewed for accidents (Resident #1).</p> <p>Immediate jeopardy began on 2/21/2024 when Resident #1 vomited an ingested pair of medical examination gloves. Immediate jeopardy was removed on 4/20/2024 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower level and severity of E (no harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put in place were effective.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included intellectual disability and PICA disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was rarely and/or never understood and she rarely and/or never understood others communicating with her. The staff assessment for mental status indicated the resident had short term and long-term memory problems, her cognitive skills for daily decision making were severely impaired, and she had inattention (difficulty focusing attention) that varied in frequency and severity. She used a wheelchair and required partial to moderate assistance (helper does less than half the effort) with wheeling 50 feet with two turns. She was dependent on others for all activities of daily living.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #1's care plan last reviewed on 1/11/2024 indicated due to her intellectual disability, she may sometimes exhibit challenging behaviors that included wandering and PICA. The goal stated Resident #1's behaviors would be managed with positive behavior and support and included different set of interventions for supervision and swallowing inedible objects. The interventions listed on the care plan for Resident #1's supervision included: standard supervision when in her bedroom that included documentation of checking her every 15 minutes; before leaving Resident #1 alone, checking that her room was clear of items that she could reach and ingest (hairbands, dryer sheets, small pieces of plastic, gloves); checking her every 30 minutes when asleep; staff continuously present and visually monitoring Resident #1 when not in her room; watching closely when self-propelling wheelchair because she is at risk for falls and PICA behavior; and watching her even when sitting still in wheelchair because she can unlock the brakes on the wheelchair brakes. The interventions due to Resident #1's history of swallowing inedible objects included: she could be [NAME] and very fast if she saw an item that she wanted to ingest; always keeping areas clear of objects within her reach she could swallow; providing redirection if she attempted to ingest an item; keeping in mind that she was capable of swallowing items that may surprise one (hair bands, dryer sheets, cotton balls, gloves, pieces of plastic); watching for signals as potential indications of PICA behaviors (frequent coughing or throat clearing, vomiting, depression, signs of nausea or stomach pain); and notifying medical staff immediately if you suspect the ingestion of something.</p> <p>On 2/21/2024 the following supervision protocol sheet dated 9/23/2020 (a listing of residents on the unit and their supervision level) was in place for unit 2-1 and listed Resident #1's supervision as standard supervision as follows:</p> <ul style="list-style-type: none"> - 15-minute checks while awake daily. - Standard bed checks 15 minutes when in bed awake and 30 minutes checks when in bed asleep. - Close visual supervision when self-propelling her wheelchair inside her unit (example: in the hallways outside the activity/day room self-propelling her wheelchair, as long as she remained in the eyesight of the staff was fine; as soon as Resident #1 is not within staff eyesight, staff must locate her quickly) and when outside (if outside self-propelling her wheelchair, staff should be with her and keep her in their eyesight to minimize distractions or any outside hazards). - She needed to be visually monitored whenever she was in her wheelchair at all times even if she was sitting still due to her ability to unlock her brakes on the wheelchair. - Monitor Resident #1 closely during the day when in her room or activity/day room and keep areas within her arms' reach clear of objects she could swallow. - Keep her environment free of all items that she would pick up and put in her mouth. Size doesn't matter if it was something she could pick up in her hands. She may try to put it in her mouth. - Do a room sweep of her room or any room she was to enter to ensure no objects were within her reach that she could ingest. <p>An observation of the facility campus on 4/15/2024 at 09:55 a.m. revealed there were three separate buildings on the campus that were housing residents. Each building consisted of four separate units and Resident #1 resided in unit 2-1 (Building 2, Unit 1).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>a. On 2/21/2024 at 2:10 p.m. Nurse #1 recorded at 9:35 a.m. that day, Resident #1 rolled herself back into the medication room; began gagging and vomited a pair of gloves. Nurse #1 recorded vital signs were checked, and Resident #1's respirations were even and unlabored, and auscultation (the action of listening to sounds from the lungs typically with a stethoscope) of the lungs was normal.</p> <p>A review of the Initial Allegation Report for an allegation of neglect completed on 2/22/2024 by Unit Consultant #1 indicated the facility became aware on 2/21/2024 at 10:10 a.m. of an incident that occurred at approximately 9:30 a.m. involving Resident #1. It was reported Resident #1 began gagging while in the medication/treatment room with Nurse #1 and Nurse #3 and vomited a pair of gloves.</p> <p>In an interview with Nurse #1 on 4/17/2024 at 1:45 p.m., she stated on the morning of 2/21/2024 after Resident #1 was administered her medications through the gastrostomy tube without any problems, she was rolled back into the hallway. She stated Resident #1 could independently self-propel her wheelchair in the hallway of the unit. She stated assigned staff were on the hall when Resident #1 was placed in the hallway, but couldn't say for certain if someone was watching Resident #1 because the staff could have been with other residents. She stated Resident #1 returned to the medication room and proceeded to vomit one inflated (filled with air) glove and then vomited another glove. She said the staff were unable to determine where Resident #1 got the gloves. At the time of the incident, she stated Resident #1 was on standard supervision with standard 15-minutes checks in the room and close visual monitoring (keep eye on) when up in wheelchair.</p> <p>In an interview with Unit Nurse Manager #1 on 4/15/2024 at 4:34 p.m., she stated on 2/21/2024 she observed two gloves on the floor in the medication room lying side by side that Resident #1 had vomited. The gloves were moist and there was no food observed in the emesis (vomit). She stated she didn't think that Resident #1 obtained the gloves when in the medication room because the door to the medication room and where the medication cart was positioned blocked Resident #1 from accessing the gloves in the glove holder on the wall in the medication room. She explained when Resident #1 was in the hallway, the staff were on the hallway getting other residents ready. She explained when Resident #1 was in her wheelchair, she was to be within a staff members eyesight.</p> <p>In an interview with Nurse Aide (NA) #2 on 4/15/2024 at 2:33 p.m. she stated the morning of 2/21/2024 Resident #1 had received a bath from the previous shift (11:00 p.m. to 7:00 a.m.). She reported she checked on Resident #1 multiple times. When Resident #1 got up to the wheelchair, she left her in the medication room to receive her medications and she proceeded to another resident's room to provide care. NA #2 stated Resident #1 was not able to stand and walk but could self-propel the wheelchair in the hallway. She explained Resident #1 was to be watched when up in the wheelchair due to PICA behaviors and stated there was someone always in the hallway. She stated when Resident #1 was in her room during the day, the assigned staff checked on her every 15 minutes to make sure no inedible objects were in her reach. When in the activity/day room, there was always someone assigned in the activity/day room to watch Resident #1 and the other residents. She explained when Resident #1 was in the activity/day room the staff were not required to document every 15-minute checks.</p> <p>A training roster dated 2/21/2024 documented Unit Nurse Manager #1 provided training on PICA behaviors and Resident #1's level of supervision to the nurse aides assigned to unit 2-1 where Resident #1 resided. The training information included the supervision level from the supervision protocol sheet dated 9/23/2020.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Documentation of a core team meeting (interdisciplinary meeting) completed by Non-Certified Unit Manager #2 dated 2/23/2024 reported on the morning of 2/21/2024 a significant event occurred with Resident #1. It was reported that after receiving her medications, Resident #1 left the medication room. She self-propelled herself back to the medication room, gagged and a pair of medical examination gloves came out of her mouth. Physician #1 was called and didn't believe the gloves had been in the body except for a few minutes and there were no adverse effects reported. The core team reported the following actions for Resident #1's PICA behavior:</p> <ul style="list-style-type: none"> - Continue standard supervision. - Continuous monitoring visually when up in wheelchair. - Staff to check and clear items in room so Resident #1 couldn't reach and ingest before leaving the room. - Communicate when assigned to Resident #1 with staff when providing activities of daily living to other residents in the unit. - Ensure someone monitored Resident #1 if assigned staff member assisting other resident in the unit. - Medication issues and anxiety needed monitoring closer at this time. - Cruise (moving about in an area with no precise destination) the hallway and notify other staff if there is reason to believe Resident #1 ingested an inedible object. <p>Recommendations from the core meeting included: enhanced supervision for Resident #1 that consisted of the every 15-minutes checks during the day and every 30 minutes checks when asleep, before leaving the room check for inedible objects in Resident #1's reach, using trash cans with closed lids and not filling trash cans to the top, and continuous monitoring visually when Resident #1 was up in wheelchair.</p> <p>There was a Physician order written on 2/23/2024 for enhanced supervision while in wheel chair for Resident #1.</p> <p>The event follow-up report completed by Floor Shift Nurse Supervisor #2 on 2/24/2024 at 2:30 a.m. indicated Resident #1 recently had an event of trying to swallow gloves on 2/21/2024. Floor Shift Nurse Supervisor #2 marked the event as not being a significant, serious, sentinel event (an unanticipated event in patient safety event that signals a need for immediate investigation and response). The event follow-up report indicated an administrative review was conducted on 2/24/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The management investigation report completed by Unit Manager #1 dated 2/28/2024 stated on 2/21/2024 Nurse #1 pushed Resident #1 back into the hallway after completing administration of medications . A few minutes later, Resident #1 rolled herself to the medication room, gagged and vomited an unknown object into her lap, she quickly grabbed the object and pushed it to the side of the wheelchair. When Nurse #3 moved the object, she discovered Resident #1 had vomited two examination gloves. While Nurse #3 stayed with Resident #1, Nurse #1 went to inform Unit Nurse Manager #1, Advocate #1 and Physician #1. The investigation could not identify which staff left gloves for Resident #1 to access and determined due to the failure to provide care or services necessary to prevent Resident #1 from accessing and ingesting gloves, there was a need to develop preventative measures to ensure Resident #1 had no access to examination gloves. The action plan included the following:</p> <ul style="list-style-type: none"> - Re-inservicing staff on PICA and the care plan for challenging behaviors related to PICA and positive behaviors for Resident #1 on 2/21/2024. It was recorded as completed on 3/8/2024. - Re-inservicing staff on supervision level and monitoring of Resident #1 on 2/24/2024. It was recorded as completed on 3/8/2024. - Holding a core meeting with management to discuss changing supervision level for Resident #1 and following through with core meeting recommendations. It was recorded as completed on 2/23/2024. -Special care instructions (specific written instructions of care communicated to staff for a resident) for enhanced supervision for Resident #1. When she was in her wheelchair, she should have continuous visual monitoring. This was recorded as completed on 2/23/2024. - Addressing staff not conducting body checks (two staff members visualizing the resident) at the end and beginning of the work shift on 2/23/2024. It was recorded as completed on 3/15/2024. <p>The Investigation Report sent to the state agency completed on 2/29/2024 by the Unit Consultant #1 indicated Resident #1 was in the medication room with Nurse #1 and Nurse #3 receiving her morning medications through her G-tube. Nurse #1 guided Resident #1 back into the hallway. A few seconds later, Resident #1 self-propelled her wheelchair back into the medication room. She began to gag and vomited a pair of examination gloves. The report stated Resident #1's ingestion of the examination gloves posed a risk of choking.</p> <p>b. Nurse #2 documented in the nurse's notes on 2/24/2024 at 2:30 a.m. the residual of Resident #1's enteral feeding was greater than 200 milliliters, and she observed small glove fragment in the enteral residual. Nursing documentation also recorded observation of coffee ground substance in the enteral residual and the gastric fluid tested positive for hidden blood. Nurse #2 recorded prior to checking the enteral residual, nursing staff reported Resident #1 was gagging. After the enteral residual was removed, Resident #1 was observed not gagging or displaying any signs of distress.</p> <p>A review of a facility event report dated 2/24/2024 at 2:00 a.m. completed by Nurse #2 reported when checking residuals at 2:00 a.m. a small part of grey glove was found in the gastric fluid. Nurse #2 documented coffee ground substance was also noted and the gastric fluid tested positive for blood not visualized in the gastric fluid. The severity index (category of injury on the event report) completed by Nurse #2 indicated there was no harm to Resident #1 and monitoring may have been required but no treatment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview with Nurse #2 on 4/16/2024 at 6:55 a.m., she stated when checking Resident #1's enteral residual on 2/24/2024 a dime size piece of glove was observed in the enteral residual. She indicated an incident report was completed with Floor Shift Nurse Supervisor #2.</p> <p>Further nursing documentation on 2/24/2024 at 7:15 a.m. by Floor Shift Nurse Supervisor #2 recorded Resident #1 was to be sent to the emergency room via Emergency Medical Services (EMS) due to no gastric intake, history of PICA and vomiting. On 2/24/2024 at 7:40 a.m. Floor Shift Nurse Supervisor #2 documented the physician was called and verified reason for transferring to emergency room was due to possible gastric outlet obstruction.</p> <p>In an interview with Floor Shift Nurse Supervisor #2 on 4/16/2024 at 8:08 a.m., he stated on 2/24/2024 he did not observe the small fragment that looked like a piece of glove found in the enteral residual by Nurse #2. He stated he was aware of Resident #1 swallowing gloves a few days earlier (2/21/2024) and called the physician and EMS. He stated an event report was completed because he did not know if the small fragment was from a new PICA incident or from the previous incident on 2/21/2024.</p> <p>In an interview with Unit Nurse Manager #1 on 4/16/2024 at 1:48 p.m., she explained when investigating the incident/event of a small piece of glove in the enteral feeding residual, she felt the piece of glove could have come from a torn/pinched piece of glove when worn by the staff when caring for the gastrostomy tube. She stated no staff member had reported gloves tearing when working with the gastrostomy tube and noted the gloves Resident #1 had swallowed on 2/21/2024 were intact when vomited.</p> <p>In a follow up phone interview with Nurse #2 on 4/16/2024 at 4:24 p.m., she stated she did not think the small fragment of glove in Resident #1's enteral residual came from a pinched/torn glove through the G-tube port. She explained the fragment of glove was not observed in the first enteral residual. She stated she removed over 200 milliliters of enteral residual, and the glove fragment was observed in the last removal of enteral residual.</p> <p>A review of Resident #1's hospital records dated 2/24/2024 reported no vomiting episodes of inedible objects, and radiology tests did not report any visualization of foreign objects in the esophagus (the muscular tube that connects the throat to the stomach), stomach and intestines or a gastric obstruction.</p> <p>In a phone interview with NA #4 on 4/19/2024 at 8:57 a.m., she explained on the night shift (11:00 p.m. to 7 :00 a.m.) beginning on 2/23/2024 and ending on 2/24/2024 when Resident #1 vomited, she did not observe any gloves or parts of a glove in the emesis (vomit). She stated she checked on Resident #1 at night every 30 minutes and ensured there were no inedible objects in her reach. She said Resident #1 did not get out of bed during the night shift, and she was not able to reach the box of gloves on the wall at the sink in her room from her bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The review of a significant, serious, or sentinel event follow-up report with an incident date of 2/24/2024 and signed by Floor Shift Nurse Supervisor #2 and Non-Certified Unit Manager #1 on 2/24/2024, Unit Nurse Manager #1 on 2/28/2024 and Unit Consultant #1 on 2/29/2024 indicated the following procedures were in place for Resident #1: 15-minute checks while awake in the room and 30-minute checks while in the room sleeping for supervision. The report stated on 2/23/2024 the core team agreed to enhanced supervision for Resident #1 which included continuous visual monitoring when in her wheelchair. The report indicated Resident #1's risk behaviors were managed by ensuring no items were left in her room within her reach, conducting a room sweep of every room she enters and following her supervision level (enhanced). The report stated Resident #1 had a history of PICA and needed to be monitored closely at all times. Recommendations for actions to be taken included conducting a core (interdisciplinary) team meeting. The completion date for the core team meeting was recorded as 2/28/2024. Other recommended actions that were recorded as ongoing with no completion date included following her supervision level at all times, doing a room sweep of any room Resident #1 went into to ensure no objects were close by and reporting all incidents of PICA to nursing as soon as noted.</p> <p>Documentation of a core team meeting (interdisciplinary meeting) completed by Non-Certified Unit Manager #1 dated 2/28/2024 reported the event of 2/21/2024 and 2/24/2024 could be linked, and Resident #1 could have swallowed some of the examination glove in the event of 2/21/2024. The core team recommended to continue enhanced supervision as recommended on 2/21/2024 and to visually monitor Resident #1 continuously when up in wheelchair and to check Resident #1 every 15-minutes when in bed or recliner during the day and 30-minute checks during the hours of sleep. Additional interventions included: (1) ensuring the room was clear of items in her reach to ingest before leaving her room; (2) communicating with fellow staff members when performing personal care to other residents to ensure someone was monitoring Resident #1 when assigned staff were with other residents; (3) having trash cans with lids that close and not filling the trash can with trash to the top; (4) staff cruising the hallway where Resident #1 resided and notify other staff members if having to leave the unit; (5) conducting a room sweep of any room Resident #1 went into to ensure no inedible objects were in her reach; and (6) monitoring more closely when Resident #1 showed signs of anxiety or experiencing medical issues.</p> <p>In an interview with the Director of Nursing (DON) on 4/16/2024 at 3:40 p.m. he stated he was aware of the incident/event on 2/24/2024 when a small fragment of glove was observed in Resident #1's enteral residual. He stated the event was investigated by the facility, and no new interventions for providing care to Resident #1 were needed. He explained a couple of days prior to 2/24/2024, the gloves Resident #1 had swallowed and vomited were intact (2/21/2024). He stated when Unit Nurse Manager #1 investigated the incident she reported she thought the small fragment of glove could have entered the gastrostomy tube (G-tube) through pinching and tearing a piece of a staff member's glove when connecting the syringe tip into the G-tube. He indicated at the time of the 2/24/2024 incident/event, Resident #1 had only exhibited PICA behavior once (2/21/2024).</p> <p>c. Nursing documentation on 3/24/2024 at 11:10 a.m. by Nurse #4 recorded nursing staff reported Resident #1 had vomited a moderate amount of emesis (vomit) and two gray gloves in the emesis. Vital signs recorded were stable, and Resident #1 was awake and alert with no distress or pain noted by Nurse #4.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER O'Berry Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Old Smithfield Road Goldsboro, NC 27533	

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview with Nurse #4 on 4/16/2024 at 7:27 a.m., she explained Resident #1 was fast in obtaining inedible objects and had been placed on enhanced supervision (someone watching her) when she was in her wheelchair after the event on 2/21/2024. She said she had heard Resident #1 gag like a wrenching sound in the last few months but had not witnessed her vomiting. She explained Resident #1 had gone years without exhibiting PICA behaviors and did not know why she had started back ingesting inedible objects. She said she did not know when Resident #1 ingested the gloves on 3/24/2024, and Floor Shift Nurse Supervisor #1 responded to the activity/day room to assess Resident #1. She further stated her concern with Resident #1 swallowing and vomiting gloves was the gloves would get stuck in her esophagus (muscular tube that connects the throat and stomach).</p> <p>A handwritten nurse's notes by Floor Shift Nurse Supervisor #1 dated 3/27/2024 stated on 3/24/2024 at 9:45 a.m. Resident #1 was found to have ingested two gloves and she was placed on one-to-one supervision for three shifts.</p> <p>In an interview with the Floor Shift Nurse Supervisor #1 on Unit 2-1 on 4/16/2024 at 8:44 p.m., she stated when she arrived in the activity/day room on the morning of 3/24/2024, NA #4 was holding a towel with small amount of emesis (vomit) and two whole gloves that were intact. She described the gloves as wet on the outside and squishy (soft, moist, able to squeeze). She stated there were food particles filling the fingers of the gloves and Resident #1 was observed in no distress. She explained the facility was unable to determine where Resident #1 obtained the gloves.</p> <p>A review of the Initial Allegation Report completed on 3/25/2024 by Unit Nurse Manager #2 indicated the facility became aware of an incident on 3/24/2024 at 10:25 a.m. of Resident #1's ingestion of gloves. The report stated while Resident #1 was unattended she ingested two gloves during a time period while in the care of a staff member (NA #2) receiving a bath and feeding. Resident #1 was transported by NA #2 to the activity/day room at 9:45 a.m. where she was in eyesight of other staff members. Within 15-30 minutes in the activity/day room, Resident #1 started gagging and vomited two gloves. Under the section of physical or mental injury/harm it indicated neglect/harm-ingestion of a foreign object- unattended.</p> <p>A revised Initial Allegation Report was completed on 3/26/2024 by Unit Nurse Manager #2 for the 3/24/2024 incident/event. The allegation stated Resident #1 ingested two gloves and in the activity/day room Resident #1 started gagging and vomited two gloves approximately 9:45 a.m. to 10:25 a.m. on 3/24/2024. Staff notified the nurse and an intervention was initiated immediately. Resident #1 was placed on one-to-one supervision.</p> <p>In an interview with NA #2 (NA assigned to Resident #1 on 3/24/2024) on 4/15/2024 at 2:33 p.m., she stated on 3/24/2024 she gave Resident #1 a shower and disposed of her gloves in the trash. She explained while providing care to another resident, NA #3 was watching Resident #1. She stated Resident #1 usually ate independently with supervision, but when she took Resident #1 to the dining area in the kitchen (the kitchen area had dining table) to eat breakfast on 3/24/2024 she acted like she wanted her (NA #2) to feed her. She said Resident #1 only ate about 50% of her meal and was not observed experiencing any problems with swallowing. She explained she took Resident #1 down to the activity/day room after breakfast where another staff member (NA #1) was present.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In a follow up interview with NA #2 on 4/16/2024 at 7:53 a.m., she stated on 3/24/2024 she gave Resident #1 a shower on the trolley (stretcher). She explained she always pushed the trolley from Resident #1's room to the shower using the door in the medication room. She stated on 3/24/2024 after showering Resident #1, she left Resident #1 within her sight at the medication door while walking down the hall to obtain Resident #1's wheelchair that was located outside Resident #1 door. NA #2 stated Resident #1 was not left in reach of any gloves while in her care.</p> <p>In a phone interview with NA #1 on 4/20/2024 at 1:50 p.m., she stated on 3/24/2024 around 10:30 a.m. while brushing Resident #1's hair in the activity/day room, the resident began to gag. She explained she observed Resident #1 gag and vomit out two gray colored gloves from her mouth. She stated Resident #1 was not observed having any trouble expelling the gloves from her mouth and was not observed in any distress after vomiting the gloves. She said she didn't know where Resident #1 got the gloves. She explained she was not assigned to Resident #1 on 3/24/2024 and was fixing her hair as requested by NA #2.</p> <p>In an interview with NA #3 on 4/15/2024 at 2:52 p.m., she stated on the morning of 3/24/2024 she watched Resident #1 while the assigned NA, NA #2, provided another resident care. She explained Resident #1 was up in her wheelchair the morning of 3/24/2024 and could self-propel her wheelchair in the hallways. She said she did not provide one-to-one supervision while watching Resident #1. She explained Resident #1 remained in her eyesight along the doorway of the hall when assisting another resident until NA #2 assisted Resident #1 in her wheelchair to the dining area in the kitchen to eat. She stated she did not see Resident #1 with any gloves while watching her.</p> <p>In an interview with Unit Nurse Manager #2 on 4/17/2024 at 12:37 p.m., she explained she was the on-call the weekend of 3/24/2024 when staff reported Resident #1 had vomited two gloves. She stated Resident #1 was immediately placed on one-to-one supervision. The glove holder in the medication room was raised to prevent residents from reaching the gloves and all trash cans on Unit 2-1 were changed to the trash cans with lids that opened with a foot pedal. She stated she could not determine when or where Resident #1 obtained the gloves to swallow.</p> <p>Documentation by Non-Certified Unit Manager #1 of the core (interdisciplinary) meeting held on 3/24/2024 recorded while NA #1 was brushing Resident #1's hair, she began to gag and vomited out one glove followed by another glove. The core team reported this was the third incident of PICA behavior in the last two months. Previous interventions to supervise and to prevent Resident #1 from accessing gloves to ingest were reviewed and continued. Resident #1 was placed on one-to-one supervision on 3/24/2024 and the core team agreed that enhanced supervision (continuous visual monitoring when Resident #1 was in her wheelchair) should continue. Lids were to be placed on all the trash cans in unit 2-1 and the core team suggested utilization of trash cans with foot pedals to prevent reoccurrences of Resident #1's ingestion of gloves. The core team reported most trash cans in unit 2-1 and the activity/day room utilized foot pedals except in the bathroom, and the bathroom trash cans had lids. Staff were to ensure lids were on the trash cans in the bathroom at all times. A work order was submitted to raise the medication room glove container higher to prevent Resident #1 or other residents from getting gloves out of the container.</p> <p>A physician order written on 3/26/2024 indicated enhanced supervision when in the wheelchair and to ensure all trash can had lids in place.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A maintenance work order dated 3/27/2024 at 12:01 p.m. by Non-Certified Unit Manager #1 requested the glove container in unit 2-1 medication room to be raised a little higher to prevent resident from reaching for gloves.</p> <p>The facility's plan of correction/interventions dated 3/24/2024 for Resident #1's ingestion of gloves included:</p> <ul style="list-style-type: none"> - Placing Resident #1 on one-to-one supervision for 24 hours. It was recorded completed on 3/24/2024. - Unit Nurse Manager #1 to access Unit 2-1 for possible sources of gloves. As a result, the following items were completed: <ol style="list-style-type: none"> 1. Removal of gloves from the tube feeding cart in the medication room by Unit Nurse Manager #1. It was recorded as completed on 3/25/2024. 2. Glove holder in the medication room was raised. It was recorded as completed on 3/28/2024. 3. Ensure all trash cans in patient care area had lids. It was recorded as completed on 3/26/2024. 4. Removal of all trash cans without lids from patient care areas. It was recorded as completed on 3/25/2024. 5. When providing care ensure trash cans were used and do not place trash bags on floor or bed. This would be monitored by Floor Shift Supervisors and Non-Certified Unit Managers. It was recorded as completed on 3/26/2024. 6. Re-inservice staff on Resident #1's care plan as related to PICA by Floor Shift Supervisor #1. It was recorded as completed on 3/24/2024. 7. Direct care staff, environmental services and supervisors were to keep the bedside free of gloves and other objects Resident #1 may ingest. It was recorded as completed on 3/26/2024. - Enhanced supervision when resident was in wheelchair. The Non-Certified Unit Manager and/or charge NA was to monitor enhanced supervision of Resident #1. It was recorded as completed on 3/26/2024. - Monitoring for compliance with all expectations to be done daily by the Floor Shift Supervisors, Unit Nurse Manager and Non-Certified Unit Managers. It was recorded as completed on 3/24/2024. - Verify and assess the strategies during the look back period of the annual review date for all residents with a diagnosis of PICA to determine effectiveness of their care plan. There were no other concerns identified. - [TRUNCATED] 		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>41387</p> <p>Based on observations, record review, responsible party interview, staff interviews and a Physician interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee had put in place in the area of abuse and neglect (F600) following the complaint investigation survey of 11/7/2023 and the complaint investigation survey of 2/23/2024. This deficient practice was subsequently recited on the current complaint investigation survey of 4/21/2024. The continued failure during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>Findings included:</p> <p>This tag is cross referenced to:</p> <p>F600: Based on observation, record review, Responsible Party interview, staff interviews and a Physician interview, the facility failed to protect Resident #1 from neglect by not implementing effective interventions to prevent a resident with a known diagnosis of PICA disorder (a mental health condition where a person compulsively eats non-food items that are harmful or toxic) from repeated incidents of accessing and ingesting medical examination gloves. On 2/21/2024, Resident #1 vomited two medical examination gloves. On 2/24/2024, a dime size object resembling a part of a medical examination glove was observed in Resident #1's enteral feeding (nutrition delivered through a tube placed into the stomach or small intestine) residual (enteral feeding not digested from the stomach). On 3/24/2024, Resident #1 vomited two medical examination gloves. On 4/5/2024, Resident #1 was found lying in bed with a medical examination glove in emesis under her pillow. The ingestion and vomiting of examination gloves created a high likelihood of serious harm such as a blockage of Resident #1's airway, choking, and aspiration (when something swallowed or vomited enters the airway or lungs). This deficient practice was for 1 of 3 residents reviewed for neglect (Resident #1).</p> <p>During the complaint investigation survey of 11/7/2023, the facility was cited for failure to protect a resident's right to be free from staff to resident verbal abuse.</p> <p>During the complaint investigation survey of 2/23/2024, the facility was cited for failure to protect a resident's right to be free from staff to resident physical abuse.</p> <p>In an interview with the Administrator on 4/17/2024 at 5:48 p.m., she stated the Quality Assurance Performance Improvement (QAPI) committee meet quarterly and had not met since the 2/23/2024 complaint investigation survey. She indicated the previous deficiency on 2/23/2024 was related to physical abuse, not neglect.</p>		