STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____ MAR 06 2019 Lic. & Cert. Section	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	140 PIRATES 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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 10 audit clients (#2, #9) had the right to be treated with dignity regarding the use of incontinence pads and client #9 was not afforded a legally sanctioned decision maker. The findings are: 1. Client #2 was not afforded dignity. During evening observations in A Wing on 2/18/19 from 5:00pm - 5:15pm and 5:55pm - 6:30pm, client #2 was seated in her wheelchair. During this time, the seat of client #2's wheelchair had an incontinence pad positioned on it. The pad was visible to anyone in the area. Interview on 2/19/19 with client #2 revealed she can let staff know when she needs to use the bathroom. Review on 2/19/19 of client #2's Individual Program Plan (IPP) dated 6/8/18 revealed the client "is able to indicate need to use the bathroom..." Additional review of the plan indicated Toileting procedures (last revised 8/28/18) which identified the use of a Hoyer Lift to assist her with sitting on a PVC rolling commode chair positioned over the toilet. Interview on 2/19/19 with the Qualified Intellectual	W 125	*** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed soley because it is required by Ithe provisiosn of the law.*** The facility will ensure the rights of all people supported are met by encourging them to exercise their rights as clients of the facility, as citizens of the United States, including the right to file complaints, and the right to due process. Person #2 can communicate her needs and will be encouraged to do so. Underpads will not be used in seating for any person supported, unless it is medically needed and agreed upon by the team with reason for need documented in Support plan. Monitoring Informal moniorting will be through daily observations by QP, Habilitation specialist, Therapeutic service Technicians and unit Supervisor/ charge will monitor Formal internal assessments will be completed at least two times monthly by QP, Habilitation specialist, Therapeutic service Technicians and unit Supervisor.	4/19/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alexandra Hamilton for Tina Stewart — TITLE: Program Manager. — (X6) DATE

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 125	Continued From page 1 Disabilities Professional (QIDP) confirmed client #2 should be using the toilet and can indicate the need to go. Additional interview indicated an incontinence pad should not be positioned on the seat of her wheelchair. 2. Client #9 was not afforded the right to legal guardianship. Review on 2/19/19 of client #9's record revealed he was his own guardian. Additional review of the client's record identified a Behavior Support Plan (BSP) dated 10/4/18. The BSP included an objective to improve his ability to control disruptive behaviors as evidenced by 5 or less targeted behaviors. Additional review of the plan included the use of Invega, Intuniv and Zoloft. The record also included an informed consent for the BSP dated 1/2/19 which had been signed by client #9. An attempt was made to interview client #9; however, the client was not able to answer questions from the surveyor. Staff interview on 2/19/19 revealed the staff had known client #9 "for a while" before he came to the facility. The staff indicated they did not believe the client was capable of managing money or understanding anything about his medications other than the names of them. Further review of client #9's Psychological Evaluation dated 10/9/18 revealed an IQ score of 45 and noted "Moderately delayed". The evaluation also noted the client scored 63, 70 and 26, respectively, for receptive, expressive and written skills. Further review of the evaluation revealed, "Ideal placement, however, would	W 125	All people living at the River Bend unit will have at minimum a person appointed for limited guardinaship to send support in the management of medication, assist with complex communication needs such as legal, medical, financial and personal rights advocacy. QP for person # 9 will petition the court for legal guardianship and will update support plan and annual consents when court appoints guardian. Teams for all others will ensure that each person has guardianship representation as needed. Monitoring will be spontaneous chart checks and formerly by quarterly chart audits by clinicians	4/19/2019

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W 125	Continued From page 2 appear to involve a smaller community living setting such as living at home or group home with supports to ensure that medical needs are met, socialization and behavior supports to include management of medications...assist with complex communication needs (e.g legal, medical, financial)...and personal rights advocacy." Interview on 2/19/19 with the QIDP revealed client #9 had signed the informed consent for his behavior plan and restrictive medications; however, she could not be sure if he understood all aspects of this form. The QIDP acknowledged client #9 needed a legal guardian. During an interview on 2/19/19, the facility's psychologist acknowledged client #9 was in need of a legal guardian.	W 125	Privacy will be ensured for all people supported at the River Bend facility. During personal care time such as at bath time, toileting, and changing time doors will be closed and/or curtains will be pulled to allow for privacy. All staff will be trained to be considerate of people supported during these times. Staff will be trained to wait to provide treatments, administer medications and not interupt until the person supported is dressed and has returned to their normal setting.	4/19/2019
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #8 was afforded the right to privacy during the care of his personal needs. This affected 1 of 10 audit clients. The finding is: Client #8's right to privacy was not respected. During observations on the Pirate Academy wing of the home on 2/19/19 at 7:45am, the nurse	W 130	DON/Nursing Designee will train LPN regarding person #8 on respecting and maintaining his right to privacy. DON or Nursing Designee will in-service nursing staff on persons served rights and maintaining their privacy. Monitoring Will occur during medication administration audits. At least one medication administration audit will be completed weekly.	

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W 130	Continued From page 3 prepared client #8's morning medications and took them into his bedroom. Upon entering the bedroom, the door to the bathroom was wide open with a staff and client #8 inside. With the client standing near the toilet completely naked, the nurse entered the bathroom and proceeded to tell the him it was time for his medicine. He was given his medicine and the nurse then left the area. Staff interview indicated client #8 does not close the bathroom door on his own without assistance. Review on 2/19/19 of client #8's Individual Program Plan (IPP) dated 8/14/18 revealed he requires staff assistance for all of his daily living needs. Interview on 2/19/19 with the Director of Nursing indicated the nurse should have considered client #8's right to privacy during the administration of his medication.	W 130	The facility will provide all staff with initial and continuing training to enable effective job performance. Staff responsible for administering medications will be trained to stay with the person and visibly observe that all medications have been taken as perscribed. DON/Nursing Designee will train LPN regarding person #8 on respecting and maintaining his right to privacy. DON or Nursing Designee will in-service nursing staff on persons served rights and maintaining their privacy. Monitoring Monitoring will occur during medication administration audits. At least one medication administration audit will be completed weekly.	
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure the nurse was trained on the policy and procedures of giving medications. This affected 2 of 2 individuals (#5, #10) observed to receive their medications in their food. The finding is:	W 189		4/19/2019

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W 189	Continued From page 4 The nurse was not trained to stay with the clients to assure they get all of their medications. During observations on 2/19/19 at 8:45am in the Solarium, client #5 was observed at mealtime. It was observed there were quite a few chunks of medication in his food. Staff sitting with him confirmed it was his medication. Client #10 also had the majority if not all of her meal left in her cups and the staff with her was interviewed. Interview with the staff with client #10 during breakfast at 8:45am on 2/19/19 revealed she knew that client #10 had medication in one of her servings of food but she did not know which serving. She stated that she thought the medication was in one serving but then changed it to another. The staff confirmed she was not medication certified and that the nurse had left the area without assuring all medications were taken. The staff working with client #5 also confirmed she was not certified and that the nurse had left. Observations on 2/19/19 of the lunch area and the room next door revealed the nurse was not in either room. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/19, during this observation, confirmed the nurse was not in the area and she should have stayed and observed the medications being taken. Interview on 2/19/19 with the nurse confirmed she had gone down the hall and left the medication in the client's food.	W 189	DON/Nursing Designee will train MT in regards to persons #5 and #10 and the importance of remaining with the person until all prepared medications are consumed. DON or Nursing Designee will in-service nursing staff in reference to Nursing Policy #1000.1 -- Medications will not be left unattended in the presence of the person being served. Monitoring Will occur during medication administration audits. At least one medication administration audit will be completed weekly.	

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W 189	Continued From page 5 Interview on 2/19/19 with the Director of Nursing confirmed the nurse should not have left medications unattended with the direct care staff and clients. She confirmed this nurse needed additional training on this aspect of medication administration. Further review on 2/19/19 of the nursing policy manual section 10 revealed the policy and procedures directing nursing staff not to leave medications unattended with the clients.	W 189		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure the Individual Program Plan (IPP) for 1 of 10 audit clients (#7) included relevant information for the direct staff to know how and when to apply oxygen via nasal cannula to client #7. The finding is: Client #7's IPP did not include the relevant information regarding when he should receive oxygen. During observations throughout the survey in the Solarium on 2/18/19 and 2/19/19, client #7 received oxygen by nasal cannula. On 2/18/19, his oxygen was set on 2.5 liters. On 2/19/19, it was set on 2.0.	W 240	Team has reviewed and revisited person #7's physician order. QP has updated support plan to ensure that all information for use of oxygen and other regular medical care matches physician's orders. IDT will be inserviced by designated person to ensure that communication in regards to updated medical orders are provided. QP's will update support plan to accurately reflect new orders and changes as revised. Monitoring Will occur during quarterly record audits by assigned clinicians to ensure that all relevant medication is included in support plans.	Completed 2/22/2019. 4/19/2019

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W 240	Continued From page 6 Review on 2/18/19 of client #7's IPP indicated nothing about his oxygen use or information regarding how or when oxygen should be used. Interview on 2/19/19 with four direct care staff, Qualified Intellectual Disabilities Professional (QIDP) and another staff revealed client #7 receives oxygen all the time. Interview on 2/19/19 with the QIDP confirmed that there is no mention of the need for supplemental or continuous oxygen use in his IPP.	W 240		
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 observations, record reviews and interviews, the facility failed to assure a pattern of interactions supported the Individual Program Plans (IPP) in the areas of medication administration, adaptive equipment schedule, positioning schedule and feeding protocol. This affected 4 of 10 audit clients (#3, #4, #7, #8). The findings are: 1. Client #7's positioning schedule was not consistently followed per the IPP.	W 249	The facility will ensure that all support plans provide patterns of continuous active treatment programs designed to promote interations supporting areas including medication administration, adaptive equipment schedule, positioning schedule and dining protocol. Team for persons #3, # 7, #4, #8 and all others will revisit the suport plans to ensure positioning protocol is accurately listed and will train staff to follow the identified positioning protocol. Monitoring: QP, Habilitation specialist, Therapeutic service Technicians and unit Supervisor/ charge will monitor informally through daily observations. Formal monitoring will be by internal assessments completed at least two times monthly by QP, Habilitation Specialist, Therapeutic service Technicians and unit Supervisor.	4/19/2019

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W 249	Continued From page 7 During observations in the Solarium on 2/18/19 from 3:30-4:45pm intermittently, client #7 was positioned on his back in a daybed at every observation. There was a positioning schedule in the shape of a clock above the daybed. It noted that between the hours of 2pm -3pm and 3pm-4pm he should be positioned on his right side. Two staff were asked if he had changed positions and they stated no. The third staff interviewed said she was about to move him. One of the three staff stated he rolls over when she does put him on his side. Review on 2/19/19 of client #7's IPP dated 3/8/18 revealed, "Staff should follow the facility positioning clock whenever he is lying down on a daybed or on his hospital bed...." Interview with management revealed he should be repositioned every 2 hours and she indicated it did not necessarily correspond with the clock on the wall. However, interview with the qualified intellectual disabilities professional (QIDP) indicated the staff should follow the IPP which notes they should follow the facility positioning clock. 2. Client #4 was not consistently fed according to her feeding protocol. During observations of lunch on 2/18/19 and of breakfast in the cafe on 2/19/19, client #4 was fed by staff without prompting her to attempt to feed herself first. Review of client #4's IPP dated 6/26/18 revealed	W 249	Team for person # 4 and all others will train all staff upon consistently following dining protocol identified by teams and listed in the support plans. Monitoring: QP, Habilitation specialist, Therapeutic service Technicians and unit Supervisor/ charge will monitor informally through daily observations. Formal internal assessments will be completed at least two times monthly by QP, Habilitation Specialist, Therapeutic service Technicians and unit Supervisor.	4/19/2019

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W 249	Continued From page 8 she will assist with feeding and sometimes bring up her built up handled spoon to her mouth. She will independently grasp open cup and assist with drinking. Interview on 2/19/19 with the QIDP confirmed the IPP should be followed and staff should attempt to get her to feed herself before beginning to feed her. 3. Client #8 was not afforded the opportunity to participate with the administration of his medications. During observations of medication administration on the Pirate Academy wing on 2/19/19 at 7:45am, the nurse dispensed client #8's medication, poured his drink, fed his pills to him and threw away the trash. Client #8 was not prompted or encouraged to participate with the administration of his medications. Review on 2/19/19 of client #8's Nursing Evaluation dated 7/3/18 revealed, "[Client #8] is able to scoop medications from the cup and place loaded contents in mouth once medications are prepared by the nurse....He can independently drink water from a cup and throw away all trash with verbal prompts." Interview on 2/19/19 with the nurse revealed client #8 can scoop on his own and feed himself. 4. Client #3's Ankle-Foot Orthosis (AFO) were not removed as indicated.	W 249	DON/Nursing Designee will train LPN to encourage person #8 to participate in his medication administration as tolerated. DON/Nursing Designee will in-service nursing staff in regards to promoting and allowing persons served to participate in their medication pass as tolerated. Monitoring Will occur during medication pass observations. At least one medication pass observation per week will be completed. Nursing or team designee will ensure that AFOs are removed according to the recommendations in the support plan, for all those with AFOs and replacennt shoes are available to be applied. Appropriate staff will be trained on the importance of following AFO application schedules. Monitoring: Will occur during spontaneous observations of those people with AFO application schedules to ensure that the schedules are accurately followed.	4/19/2019

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W 249	Continued From page 9 During observations in the Pirate Academy classroom on 2/18/19 at 6:35pm, client #3 was wearing AFO's on both legs/feet. Review on 2/18/19 of client #3's IPP dated 1/15/19 revealed the client wears bilateral AFOs which should be applied at 6:30am and removed at 5:30pm. Interview on 2/19/19 with the QIDP confirmed client #3's AFOs are applied and removed daily by nursing staff as indicated in her plan.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #1's objective data was documented in measurable terms. This affected 1 of 10 audit clients. The finding is: Client #1's behavior data was not collected as indicated. During afternoon observations in A School on 2/18/19 from 12:23pm - 1:30pm, client #1 wore arm splints on both arms which restricted his ability to bend his arms. Review on 2/19/19 of client #1's Behavior Support	W 252		

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W 252	Continued From page 10 Plan (BSP) dated 5/16/18 revealed an objective to address tissue damage associated with self-injury for 12 of 12 consecutive months. The plan incorporated the use of protective devices including long arm devices which restricted his ability to bend his arms and engage in self-injurious behaviors. Additional review of the plan noted, "He can wear approved protective devices for up to one hour and fifty consecutive minutes...Protective devices must be checked every 30 minutes to assess his circulation and proper fit of devices...Time in and out of devices must be documented on data sheets." Further review of data sheets dated 2/9/19 - 2/18/19 for the use of protective devices revealed incomplete or missing information for the following days: 2/10/19, 2/13/19 (2 times) 2/14/19 2/18/19 (3 times) The data sheets also did not include the observation from 2/18/19 from 12:23pm - 1:30pm. Interview on 2/19/19 with the Qualified Intellectual Disabilities Professional (QIDP) and Psychologist confirmed staff should document the use of restrictive devices as indicated.	W 252	Restraint data form modified to provide support staff method to specifically document if each individual device is removed and/or checked within required time frame (mandatory 10 minute out of restraint during each two hour period; cannot wear for longer than one hour and fifty minutes during two hour period). Efforts will be made to assign 1:1 support staff to be responsible for ensuring that mandatory restraint free period is provided. Monitoring Behavior specialists, charges and supervisors will be responsible for monitoring data sheets at least once daily to ensure that mandatory out of restraint periods are documented appropriately and any issues associated with documentation is addressed in timely manner.	
W 306	PHYSICAL RESTRAINTS CFR(s): 483.450(d)(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is	W 306		

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W 306	Continued From page 11 employed. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1 had the opportunity for motion and exercise for a period of not less than 10 minutes for every two hour period in which restraints are used. This affected 1 of 10 audit clients. The finding is: Client #1's restrictive arm splints were not removed as indicated. During observations in A school on 2/18/19 - 2/19/19, client #1 wore arm splints on both arms. The splints extended his arms out to his sides and prevented him from bending them. The splints were not observed to be removed. Review on 2/19/19 of client #1's Behavior Support Plan (BSP) dated 5/16/18 revealed an objective to address tissue damage associated with self-injury for 12 of 12 consecutive months. The plan incorporated the use of protective devices including long arm splint devices which restricted his ability to bend his arms and engage in self-injurious behaviors. Additional review of the plan noted, "He can wear approved protective devices for up to one hour and fifty consecutive minutes...Long arm devices must not remain on for longer than one hour and fifty minutes...Most important thing is that each part of [Client #1's] body is out of protective devices for at least 10 consecutive minutes during every two hour period. This is mandatory." Further review of BSP data sheets dated 2/9/19 - 2/18/19 revealed the protective devices had been	W 306	Behavior support plan was addended to address alternative strategies to ensure mandatory 10 minutes out of restrictive devices during every two hour period. (cannot wear longer than one hour and fifty minutes during two period). Written assessment will be completed by support staff approved to work 1:1 to ensure that staff aware of responsibility. Monitoring Behavior specialists, charges and supervisors will be responsible for monitoring data sheets at least once daily to ensure that mandatory out of restraint periods are documented appropriately and any issues associated with documentation is addressed in timely manner.	2/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	140 PIRATES ROAD NEW BERN, NC 28562

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W 306	Continued From page 12 worn for a total of two hours on the following days with no documented removal times: 2/9/19 (11:50am - 1:50pm, 2:00pm - 4:00pm) 2/13/19 (6:00pm - 8:00pm) 2/18/19 (6:30am- 8:30am, 8:40am - 10:40am) Interview on 2/19/19 with the Qualified Intellectual Disabilities Professional (QIDP) and Psychologist confirmed client #1 should have time out of his protective devices as indicated and this needs to be documented.	W 306	Nursing Designee contacted medical provider on 2.19.19 to obtain an order to discontinue PRN order for application of oxygen. A new order was obtained for continuous oxygen administration and provided for QP to update in person's plan.	Completed 2/19/2019
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure all physician's orders were followed as written. This affected 1 of 10 audits (#7). The finding is: Client #7's physician's order for oxygen use was not followed as written. During observations throughout the survey in the Solarium on 2/18/19 and 2/19/19, client #7 received oxygen via nasal cannula. On 2/18/19, his oxygen was set on 2.5 liters. On 2/19/19, it was set on 2.0. Review on 2/18/19 of client #7's Individual Program Plan (IPP) indicated nothing about his oxygen use. The current physician's order dated	W 368	Monitoring: Will be conducted through review of EMAR documentation to ensure that PRN orders for oxygen administration are not used as a routine order. Nursing Designee will review EMAR's of those individuals with PRN oxygen orders weekly to ensure that orders are being followed as written.	4/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 368	Continued From page 13 1/23/19 revealed he should be provided with 2 liters of oxygen for O2 less than 92%. Interview on 2/19/19 with four direct care staff, the Qualified Intellectual Disabilities Professional (QIDP) and another staff revealed client #7 receives oxygen all the time. Interview on 2/19/19 with the QIDP confirmed that there is no mention of oxygen in his IPP. she confirmed what the physician's order stated. Interview on 2/19/19 with the nursing director confirmed the order is current. She also revealed documentation of the vitals which included the pulse oxygen for client #7. Review on 2/19/19 of the vitals indicated the following for the month of February 2019 which revealed his oxygen never reached the required pulse oxygen level to receive oxygen: 2/1 - 96% 2/2 - 93-96% 2/3 - 96-94% 2/4 - 96% 2/5 - 96% 2/6 - 97% 2/7 - 96% 2/8 - 96% 2/9 - 97% 2/10 - 95% 2/11 - 97% 2/12 - 96% 2/13 - 93-98% 2/14 - 97% 2/15 - 98% 2/16 - 96% 2/17 - 97%	W 368		

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W 368	Continued From page 14 2/18 - 98%	W 368		