

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

PRINTED: 03/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASWELL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2415 W. VERNON AVENUE KINSTON, NC 28501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS	W 000			
W 242	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii)</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews, the individual support plan (ISP) for 1 of 10 audited clients (#2) failed to include objective training to address identified needs relative to tooth brushing sensitivity. The finding is:</p> <p>Client #2 did not have training objectives to address tooth brushing needs.</p> <p>Review on 3/6/19 and 3/8/19 of client #2's record revealed a dental oral examination dated 3/8/18: Client #2 had heavy build up of plaque, light calculus, advanced periodontitis and needed tooth #27 extracted. The dental exam recommended using tartar control toothpaste and a toothbrush. Client #2's record revealed an ISP dated for 6/6/18 with no current training objective</p>	W 242			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(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.

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

PRINTED: 03/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASWELL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2415 W. VERNON AVENUE</b> <b>KINSTON, NC 28501</b>		
(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 242	Continued From page 1 to address client #2's tooth brushing needs.  Observation on 3/8/19 at 11:50 am revealed staff returned client #2 to her room, but was not observed attempting to brush her teeth. Staff stated that normally a swab was used to clean client #2's mouth. The nurse fed client #2; no tooth brushing was observed after client #2's lunch meal.  Interview on 3/8/19 with the supervisor revealed staff were supposed to brush client's teeth after meals. Client #2 does not like to get her teeth brushed, so staff had been instructed to use swabs to clean the gums and remove food debris. The supervisor was unaware if client #2 had any objectives in her ISP to get her to tolerate tooth brushing.	W 242			
W 348	DENTAL SERVICES CFR(s): 483.460(e)(1)  The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.  This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to follow dental recommendations for treatment of broken, loose or infected teeth of 1 of 10 audited clients (#2) in a timely manner. The finding is:  Client #2 did not receive dental treatment in a timely manner.	W 348			

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

PRINTED: 03/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASWELL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2415 W. VERNON AVENUE KINSTON, NC 28501</b>		
(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 348	<p>Continued From page 2</p> <p>Review on 3/6/19 of client #2's record revealed a Dental Oral Examination on 3/8/18. It was noted that client #2 had heavy build up of plaque with advanced periodontitis as well as needed to have tooth #27 extracted. The annual dental evaluation on 4/6/18 revealed on 3/13/18, client #2 had a prophylaxis procedure performed to remove heavy plaque build up. The tooth was not extracted at that time.</p> <p>Continued review on 3/6/19 of client #2's record revealed a nurse's note dated 2/22/19, client #2 refused to eat lunch and had a slight tremor to her lower extremity and had facial grimace. The 2/26/19 nurse's note revealed that staff had expressed concern of client #2 lose tooth. On 3/2/19, the nurse's note revealed that client #2 had facial grimacing and moaning.</p> <p>Interview on 3/8/19 with management staff revealed the facility was negotiating a new dental contract to replace the dentist. The former dentist had been on leave between Dec 2017-August 2018. The facility sought the services of local dentists to treat their clients. When their dentist returned in Aug 2018, an expectation had been expressed that client's with the most urgent dental needs would be seen first. Appointments were scheduled for those client's however were canceled for unknown reasons.</p> <p>Interview on 3/8/19 with the Chief Advocate revealed on 10/15/18 an inquiry had been filed to address the clients that had not received dental care. When the medical records were reviewed by management, they were able to substantiate that the clients dental care had been neglected by the former dentist.</p>	W 348			

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

PRINTED: 03/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASWELL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2415 W. VERNON AVENUE</b> <b>KINSTON, NC 28501</b>		
(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 348	Continued From page 3  Interview on 3/8/19 with the House Manager revealed she could not recall if client #2 had any scheduled dental services at the end of last year. The manager further stated that staff have not brought any concerns to her attention regarding dental pain or discomfort for client #2.	W 348			