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	34G001	A. BUILDING _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A Recertification and Complaint Survey was completed on 3/20/19. No deficiencies were cited as a result of a complaint survey. Intake #NC00149706.	W 000		
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, interviews and record review, the facility failed to ensure the rights of 1 of 2 audit clients (#17) in Delta by failing to assure client dignity related to the use of incontinence padding. The findings is: Client #17 was not afforded dignity regarding the use of incontinence pads. Upon arrival in Delta on 3/19/19 at 11:10am, client #17 was seated on a chair in the living room. Additional observations revealed the client had a large incontinence pad positioned underneath him. The padding was visible to anyone in the home. Immediate interview with Staff E revealed client #17 was seated on the incontinence pad just in case he has a toileting accident so he "won't mess up the chair". Additional interview indicated the client is taken to the bathroom every hour for toileting.	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 125	Continued From page 1 Review on 3/19/19 of client #17's Individual Program Plan (IPP) dated 11/1/18 revealed he wears incontinence products due to toileting accidents. Additional review of the client's Educational Assessment dated 9/28/18 noted, "[Client #17] will occasionally initiate toileting by walking toward or propelling his wheelchair toward the bathroom. He sits on the commode independently from a standing position..." The IPP also indicated, "[Client #17] relies on Delta to...advocate for his rights..." Further review of the client's Rights of the Individual assessment dated 11/1/18 indicated the client has "The right to be treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment and in care of personal needs." Interview on 3/19/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the incontinence pad should not have been positioned underneath client #17 while seated on the chair and this "was a mistake".	W 125		
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 reviews and interviews, the facility failed to assure all individuals were afforded privacy. This affected 1 of 2 audit clients in Magnolia (#3) and 1 of 2 of audit clients in Byrum (#15). The findings are:	W 130		

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W 130	Continued From page 2 1. Client#3 residing in Magnolia was not afforded privacy during toileting. During observations in Magnolia cottage on 3/18/19 at 11:35am, client #3 was observed to go into the bathroom. He left the door open. After a few minutes, staff C came and stood in the doorway with the door open and verbally prompted him to wash his hands. Additionally at 12:40pm, client #3 was using the bathroom with the door open. He finished using the toilet, flushed it and walked out and into his bedroom without staff assistance to wash his hands or close the door for privacy. Interview with staff C revealed that client #3 does not know to close the door. She stated they have to tell him to close it but by then it is usually too late. When asked how does she know when he goes to the bathroom, she stated she sees him. When told he had just gone to the bathroom at 12:40pm and left the door open, she indicated she was surprised. She confirmed she did not realize he had gone to the bathroom. Review of client #3's individual program plan (IPP) dated 12/3/18 revealed an educational assessment dated 11/20/18 which indicated client #3 "does not recognize the need for privacy and therefore staff ensure his privacy by closing" the door for him. It also noted he needs supervision and that when toileting he should be "in the visual field always to ensure cleanliness." It further noted he required assistance to protect his rights. Interview with management on 3/20/19 confirmed all clients should be afforded privacy.	W 130		

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W 130	Continued From page 3 2. Client #15, residing in Byrum, was not afforded privacy during toileting. During observations on 3/19/19 at 8:20am, client #15 had left the dining room after breakfast and was accompanied by staff I to the shared bathroom on the hall. The bathroom door swung open, when a client exited the bathroom. Standing on the hall, outside of the bathroom, client #8 was observed standing at the sink, brushing her teeth. The stall straight ahead, was open with client #15 inside with Staff I. Client #15 could be observed standing with pants down, then sitting on toilet, with staff I by her side. Minutes later, the door to the bathroom was opened by two other clients entering. Staff I was still observed standing in the open stall with client #15 sitting on toilet. Staff I hurriedly, slid the bathroom door shut. Interview with staff I on 3/19/19 revealed when she assisted client #15 with toileting, she forgot to slide the door close. Staff I stated every client should be afforded privacy and that it was an oversight. Interview with management on 3/19/19 regarding privacy revealed that whenever personal care was occurring, the client should be afforded privacy.	W 130		
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,	W 189		

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W 189	Continued From page 4 efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff were sufficiently trained to prepare specially-prescribed diets for 2 of 2 audit clients (#5, #13) in Gamma. The findings are: Staff were not adequately trained to prepare food textures/consistencies as indicated. a. During observations in Gamma on 3/19/19 at 7:32am, Staff C used a small chopper to grind up sausage patties for client #13's breakfast. The staff did not add any liquid to the sausage. The staff also prepared a package of instant grits by adding hot water to the grits and heating them in the microwave. In addition, the staff placed a small cup of sliced peaches in the chopper and ground them up. Once finished, the grits were thick and the sausage was a ground consistency as well as dry and chunky. Further observations of client #13 at the breakfast meal revealed the client coughing after approximately half of her food was consumed. Interview on 3/19/19 with Staff C revealed client #13 receives a pureed diet and the food she prepared for client #13 was pureed. Review on 3/19/19 of client #13's Individual Program Plan (IPP) dated 10/16/18 revealed she receives an 1700 calorie pureed diet. Additional review of the client's current physician's orders dated 3/15/19 and a Swallowing Evaluation dated 1/27/06 also indicated she should receive a pureed diet.	W 189		

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W 189	Continued From page 5 b. During observations in Gamma on 3/19/19 at 8:15am, Staff D prepared waffles, a sausage patty and two small cups of fruit (pears and peaches) for client #5. The staff used a small chopper to grind up the items adding hot water to the sausages and milk to the waffles. Once finished, the waffles were moist with visible bits of food and the sausage was moist with visible bits of meat. Additional observations of client #5 at the breakfast meal revealed the client coughed at least once towards the end of the meal. Interview on 3/19/19 with Staff D revealed client #5 receives a pureed diet which is "loose" and "looks like pudding" and should not be "too loose or liquidy". Review on 3/19/19 of client #5's IPP dated 10/23/18 revealed she receives a 1500 calorie pureed diet. Additional review of the client's current physician's order dated 2/15/19 also noted a 1500 calorie pureed diet. Additional observation of a note posted in the meal preparation area revealed a pureed diet should resemble a "mashed potatoes consistency". Additional review of staff training documentation revealed Gamma staff had received training on various dining protocols for clients in the home, including client #5 and client #13. However, no training on the preparation of food textures/consistencies was available. Interview on 3/19/19 with the Occupational Therapy (OT) assistant revealed a ground consistency would resemble chopped barbeque	W 189		

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W 189	Continued From page 6 and pureed food should resemble "baby food". Additional interview indicated OT staff do not provide training on the correct preparation of food textures, only on each client's dining protocol. Additional interview on 3/19/19 with the Division Director, Qualified Intellectual Disabilities Professional (QIDP) and Home Supervisor confirmed staff have not received formal training regarding the preparation of food textures/consistencies. Management staff revealed the direct care staff are generally monitored by shift supervisors to ensure foods are prepared as indicated; however, no documentation was available. The Division Director and QIDP acknowledged more staff training on the appropriate preparation of food textures needed to be done.	W 189		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to provide a pattern of positive interactions to support 1 of 3 audit clients (#2) who resided in Parrott. The finding is: Direct Care staff failed to provide a pattern of interactions that supported audit client #2 in the area of meal preparation. During observations on 3/19/19 at 4:20pm of meal preparation, in the Parrott Residence Unit	W 268		

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W 268	Continued From page 7 #4, staff #B asked client #2 to come into the kitchen. Staff #B asked client #2 to assist putting bread into the food processor. She verbally cued him to push the start button of the food processor. As he activated this, pieces of bread came out of the top of the food processor onto the counter in the kitchen. Staff explained the clip that holds the food processor was not working. While she was talking, client #2 activated the food processor again and additional bread was expelled out of the top of the food processor. She moved client #2's hand away from the start button and told him, " No! Stop doing that!" Staff #B asked client #2 to assist her in scooping cooked cabbage from a pot on the stove into a container. Client #2 pulled his hand back and stepped away from the stove. Staff #B told client #2, "You are just being lazy." Client #2 sat down in a chair near the kitchen counter. Staff #B again asked client #2 to assist her with the cooked cabbage on the stove. Client #2 sat back down in the chair. Staff #B told client #2, " You are just being a supervisor today." Interview on 3/19/19 with staff #B revealed she was not aware of any other cueing method to encourage client #2 to assist with meal preparation. When asked how she would respond if she overheard another staff calling a client "lazy", she stated, " I would just think it was a joke." Interview on 3/19/19 with the Division Director for the Parrott Residence revealed all staff are trained on interaction and teaching techniques. She stated the above observation was not an example of an acceptable teaching technique per their facility policies. She stated all clients should be treated with dignity and respect. Further	W 268		

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W 268	Continued From page 8 interview revealed referring to client #2 as "lazy" was unacceptable. Additional interview revealed she was contacting the Advocacy Department to question staff #B to further investigate this interaction.	W 268		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 2 of 2 audit clients (#3 and #12) residing in Magnolia received training in self-administration of medication based on an accurate assessment and not based on diagnosis. The finding is: Client #3 and #12 were not trained in self-administration of medications. A. During observations of the medication administration pass in Cypress on 3/19/19 at 8:10am, client #12 came to the medication cart and the nurse did not greet him as she punched out his pills. Direct Care staff then told client #12 to say hello to the nurse and the nurse responded to the client. However, the nurse then continued punching the client's pills without telling him what the pills were or why he was taking the pills. She then scooped the pills into a spoon and fed them to him. He then took a cup of water and drank it.	W 371		

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W 371	Continued From page 9 The nurse then gave the direct care staff a napkin and she prompted him to wipe his mouth before walking away. Review on 3/19/19 of the nursing evaluation dated 4/5/18 revealed that client #12 is "unable to pour liquid medication "due to level of distractibility, client is unable to follow commands to pour any liquid medications to a pre-measured line." It also stated he is not able to recognize meds by name or purpose; he is "unable to verbalize side effects of current medications"; he is easily distracted unable to remain on task with any consistency, unable to open pharmacy containers"; "would not be able to apply topical "due to distractibility" : can not make a mark to chart medications "due to level of distractibility"; and that he has no potential for formal self medication training "due to distractibility." Interview with the nurse supervisor on 3/19/19 revealed the "due to distractibility" statement on the assessment was based upon his "diagnosis." She further confirmed that client #12 is fed his medications even though he can feed himself at mealtime. The interview also revealed that client #12 does not have any training and that the nurse did not ask him or tell him about any of his medications. B. During observations on 3/19/19 of the medication administration pass at 8:15am, client #3 was asked to perform the simple task of getting his water and he did so independently. He then approached the medication administration cart. The nurse took out the packets and punched them all and then put them into an empty pill bottle. During this time, she said nothing to client #3. He took the pill bottle	W 371		

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W 371	Continued From page 10 when it was handed to him and took the pills with water he prepared and brought with him from the kitchen. He was not asked to make a mark to chart his medications. Review on 3/20/19 of the individual program plan (IPP) dated 12/3/18 revealed an assessment of self medication administration skills. This assessment check list indicated client #3 can transfer prepared pills from a non-child proof bottle. It indicated he cannot recognize purpose and does not know side effects. It further noted he cannot apply topicals and can make a mark to chart his medications and does not understand simple tasks. Interview with the nurse supervisor on 3/20/19 confirmed that client #3 was not told anything about his medications and did not have any training on self-medication administration.	W 371		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure a sanitary environment was provided to avoid transmission of infection and to prevent possible cross contamination. This potentially affected all clients residing in Byrum. The finding is: Precaution was not taken to promote a healthy and safe environment and prevent possible cross contamination.	W 454		

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W 454	Continued From page 11 During observations on 3/19/19 at 7:44am, staff H and client #8 were in the kitchen, wearing disposable gloves, preparing pancakes and toast for breakfast. Staff H was observed, reaching across the counter, lifting the lid of the trash can, with gloved hand, to throw an item away. Staff H did not change her gloves afterwards. Staff H took three slices of bread from plastic wrapper, wearing the same gloves and placed the bread into a food processor. The contents were poured into a bowl, however, some of the contents were stuck on the inside of the bowl of the food processor. Staff H was observed, taking gloved hand, to make a sweeping motion along the inside of the bowl, in order to remove the contents. Additional observations during breakfast, staff H continued to wear the same disposable gloves. Staff H carried the bowl of the food processor to the sink, washed the dish, while wearing gloves, and then returned to the bowl to the counter. Staff H was observed using right gloved hand to open lid of trash can to throw item away, then removed cereal bowls from the cabinet. Afterwards, staff H used gloved hand to touch door handle to exit the kitchen. When staff H returned to the kitchen, staff H was observed wearing gloves. Staff H disassembled the food warmer equipment, used gloved hand to open trash can lid to throw away aluminum foil, then walked to the sink to rinse out pans. Staff H removed large cans of vegetables from the cabinet, opened the containers, poured contents into large bowl. Staff H then removed her disposable gloves. Interviewed staff H on 3/20/19 regarding glove use during food handling. Staff H stated that	W 454		

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W 454	Continued From page 12 gloves should be changed any time something different was handled, for example, garbage or meat. Staff H offered no explanation for the observations from yesterday's breakfast food handling, with gloves. Interviewed staff J on 3/20/19 regarding glove use during food handling. Staff J stated that she washed her hands before putting on gloves. Staff J would change gloves to wash dishes and when she left out of the kitchen door. Staff J stated that the trash can lid was never touched, because there was a foot petal to operate the lid.	W 454		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 audit clients (#5, #13) in Gamma and 2 of 2 audit clients (#6, #14) in Johnson received their specially-prescribed diets as indicated. The findings are: 1. Clients (#5, #13) did not receive their pureed diets as indicated. a. During observations in Gamma on 3/19/19 at 7:32am, Staff C used a small chopper to grind up sausage patties for client #13's breakfast. The staff did not add any liquid to the sausage. The staff also prepared a package of instant grits by adding hot water to the grits and heating them in	W 460		

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W 460	Continued From page 13	W 460		

the microwave. In addition, the staff placed a small cup of sliced peaches in the chopper and ground them up. Once finished, the grits were thick and the sausage was a ground consistency as well as dry and chunky. Further observations of client #13 at the breakfast meal revealed the client coughing after approximately half of her food was consumed.

Interview on 3/19/19 with Staff C revealed client #13 receives a pureed diet and the food she prepared for client #13 was pureed.

Review on 3/19/19 of client #13's Individual Program Plan (IPP) dated 10/16/18 revealed she receives an 1700 calorie pureed diet. Additional review of the client's current physician's orders dated 3/15/19 and a Swallowing Evaluation dated 1/27/06 also indicated she should receive a pureed diet.

b. During observations in Gamma on 3/19/19 at 8:15am, Staff D prepared waffles, a sausage patty and two small cups of fruit (pears and peaches) for client #5. The staff used a small chopper to grind up the items adding hot water to the sausages and milk to the waffles. Once finished, the waffles were moist with visible bits of food and the sausage was moist with visible bits of meat. Additional observations of client #5 at the breakfast meal revealed the client coughed at least once towards the end of the meal.

Interview on 3/19/19 with Staff D revealed client #5 receives a pureed diet which is "loose" and "looks like pudding" and should not be "too loose or liquidy".

Review on 3/19/19 of client #5's IPP dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G001	A. BUILDING _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL CENTER	**2415 W. VERNON AVENUE KINSTON, NC 28501**

(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 460	Continued From page 14 10/23/18 revealed she receives a 1500 calorie pureed diet. Additional review of the client's current physician's order dated 2/15/19 also noted a 1500 calorie pureed diet. Additional observation of a note posted in the meal preparation area revealed a pureed diet should resemble a "mashed potatoes consistency". Interview on 3/19/19 with the Occupational Therapy assistant revealed a ground consistency would resemble chopped barbeque and pureed food should resemble "baby food". 2. Clients #6 and #14 diet consistencies were not followed. a. During dinner observations in Johnson 101 on 3/18/19, client #6 consumed a meal of the following: meatloaf, green peas, carrots and one roll. Further observations revealed the meatloaf was presented on client #6's plate as a 7 inch loaf. At no time was client #6 prompted to cut his food. Additional observations revealed client #6 used his spoon to break apart the meatloaf and when he consumed it the pieces where 2 inch hunks. Additional observations revealed client #6 did not have a knife at his place setting. Review on 3/18/19 of client #6's dinning card dated 11/4/15 stated, "Things to know: ...To ensure he cuts food into appropriate size pieces of 1 inch...." Review on 3/18/19 of client #6's comprehensive evaluation dated 10/17/18 revealed, "Dining: [Client #6] cuts his meat independently with some	W 460		

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 460	Continued From page 15 occasional assistance to ensure the correct size pieces...." During an interview on 3/19/19, Staff A revealed client #6 can independently cut his own food. Further interview revealed if it is not cut in the appropriate size, staff are to assist client #6. b. During dinner observations in Johnson 101 on 3/18/19, client #14 consumed a meal of the following: meatloaf, green peas, carrots and one roll. Further observations revealed the meatloaf was presented on client #14's plate as a 7 inch loaf. At no time was client #14 prompted to cut his food. Additional observations revealed client #14 used his fork to break apart the meatloaf and when he consumed it, the two to three pieces where 2 inch hunks. Additional observations revealed client #14 did not have a knife at his place setting. During breakfast observations in Johnson 101 on 3/19/19, client #14's meal consisted of the following: 3 pancakes, 1 whole slice of toast and cereal. Further observations revealed client #14 used his fork and knife to break apart the pancakes. Additional observations revealed the pancake pieces where longer that 1 inch when consumed. At no time was client #14 prompted to cut his pancakes into smaller pieces. Review on 3/18/19 of client #14's dining card dated 10/23/12 stated, "Things to know: ...To cut his food into 1 inch pieces and take bite from a whole...." Review on 3/18/19 of client #14's comprehensive evaluation dated 4/25/18 revealed, "Dining: [Client #6] may need some occasional assistance	W 460		

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W 460	Continued From page 16 to cut his food with a knife and fork....." During an interview on 3/19/19, the Occupational Therapist stated, "The best practice for dining is a Caswell policy. Food should be cut one inch or smaller." During an interview on 3/19/19, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #14 can cut his food, but might need some assistance to ensure it is cut into bite size pieces.	W 460		