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	34G265	A. BUILDING _____ B. WING _____	C 08/23/2019

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W 000	INITIAL COMMENTS An on-site complaint survey was completed for Intakes: NC00154942, NC00154946, NC00154958, NC00154684. Deficiencies were cited. It was determined the COP of Client Protections was out of compliance.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure that all allegations of neglect and abuse were reported immediately to the administrator and to other officials in accordance with state law (W153); and failed to provide evidence that all alleged violations were thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections.	W 122		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of investigations, client records	W 153		

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

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and interviews, the facility failed to report all allegations of abuse or neglect to Health Care Personnel Registry (HCPR) and to the administrator within 24-Hours as required by N.C. General Statute 131E-256, which is under 131E Article 15. This affected 5 of 5 sampled clients at the facility (#6, #7, #20, #24, #29) . The findings include:

A. Allegations of mistreatment were not reported to the Administrator or HCPR regarding client #7.

Review on 8/22/19 of written allegations from Facility Nurse A to the Director of Nursing (DON) dated 8/8/19 alleged during client #7's bath on 8/7/19 the Mickey button was pulled out of client #7's gastrostomy. When the Facility Nurse A tried to insert the Mickey Button, staff A took it out of the Nurse's hand and said, "I'll do it." Nurse A took the button back and got it reinserted into the gastrostomy. Nurse A also alleged that staff A poked around in client #7's gastrostomy trying to to jab the Mickey button in. She also alleged she shoved the sharp end of a Q-Tip in the button. This statement was signed by Facility Nurse A and dated 8/8/19.

Interview on 8/22/19 with Facility Nurse A revealed she had approached the Director of Nursing with concerns about staff A interfering with her replacing a Mickey Button for client #7. She stated she gave a written statement on 8/8/19 of these allegations to the Director of Nursing.

Interview on 8/22/19 with staff A revealed she had been assisting with client #7's bath on 8/7/19 when his Mickey Button came out of gastrostomy. She stated she contacted Facility Nurse A to

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assist her with putting the Mickey Button back into the Gastrostomy. Additional interview revealed facility nurse A tried more than once and was having difficulty. Staff A stated she had watched the Nurses several times reinsert the Mickey button for client #7. She stated that she tried to assist the Nurse and took the Mickey button away from her. She stated Nurse A was very upset but Nurse A was able to replace the Mickey Button. Staff A then asked the surveyor," What did she [The Nurse] tell you that I did? Why would she tell on me when I was trying to help her?" When asked if the DON had interviewed her about these allegations, she stated, "No."

Interview on 8/22/19 with the Director of Nursing revealed she had received allegations involving client #7 on 8/8/19 involving his Mickey Button being pulled out and staff A trying to reinsert his Mickey Button and poking a Q-Tip into client #7's gastrostomy. The DON stated these allegations had not been investigated. When asked if she had told the administrator about the allegations, she stated the administrator was away from work for several days and she did not contact her. Additional interview confirmed these allegations were also not reported to Health Care Personnel Registry. The DON stated she had held onto these allegations and asked facility Nurse A to come to her office to talk with her on 8/12 and 8/13. However, Facility Nurse A did not come to her office. Additional interview confirmed these allegations were dated 8/8/19 the day after the incident on 8/7/19. The DON confirmed these allegations were considered late reporting according to facility policy. Further interview confirmed she did not report these allegations to the administrator.

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Review of the facility's policy (dated October 2018) on reporting allegations of mistreatment revealed, "The agency will ensure proper notification of the Health Care Personnel Registry, pursuant to to state requirement G.S. 131-E-255-256. The administrator, or designee will submit a 24 hour initial report to the Department of Facility Services Health Care Personnel Registry within 24 hours after an allegation has been reported to the facility."

Additional review of the facility's policy revealed, "The Administrator/Designee will begin each investigation within 24 hours of an allegation of abuse, neglect, exploitation, or any injury of unknown origin. The investigator will determine if the staff member alleged to have committed the act of abuse should be suspended immediately for the duration of the investigation, or if clinical supervision is needed in lieu of suspension, and take necessary action to assure the safety of all people involved."

Review of facility policy (102.052) revealed, "Neglect is generally defined as the failure to provide services and supports necessary to protect a person from serious and/or psychological harm. Unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk of harm."

Interview via phone on 8/22/19 with the Director of Operations for the facility confirmed the allegations involving client #7 and facility Nurse A on 8/7/19 were not reported to him. Additional interview revealed these allegations should have

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been reported to the administrator and to HCPR per their company policy to investigate possible harm to client #7. Additional interview confirmed these allegations were reported on 8/8/19 a day after the incident occurred on 8/7/19 and this was considered delayed reporting according to their company policy.

Further interview on 8/23/19 confirmed facility management made the decision to to suspend the Director of Nursing, direct care staff A and Facility Nurse A on 8/22/19 upon learning of these allegations until the allegations could be further investigated.

B. The Director of Nursing also failed to report the following allegations to the Administrator in conjunction with the facility's policy:

Review on 8/22/19 of a written statement by facility Nurse A to the Director of Nursing dated 8/8/19 revealed the following :

1. Three direct care staff (staff A, staff F and staff G) put four clients #6, #20, #24, #29 to bed on 8/7/19 following their return from the school building around 3pm until Saturday 8/8/19 around 7-9am.

2. Direct care staff (staff A, staff F and staff G) were putting clients #6, #20, #24, #29 to bed on Fridays at 3pm when they returned from school and leaving them in their beds until Monday around 7-9am.

Interview on 8/23/19 with the Administrator and the Director of Operations confirmed these allegations were not reported to the Administrator after being given to the Director of Nursing on

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W 153	Continued From page 5 8/8/19.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to consider all sources of evidence to thoroughly investigate allegations of mistreatment involving 5 of 5 sampled clients (#7, #6, #20, #24, #29). The findings include: A. The facility failed to thoroughly investigate allegations of mistreatment for client #7. Review on 8/22/19 of written allegations from Facility Nurse A to the Director of Nursing (DON) dated 8/8/19 alleged during client #7's bath on 8/7/19 his Mickey button was pulled out of his gastrostomy. When the Facility Nurse A tried to insert the Mickey Button, staff A took it out of the Nurse's hand and said," I'll do it." Nurse A took the button back and got it reinserted into the gastrostomy. Nurse A also alleged that staff A poked around in client #7's gastrostomy trying to jab the Mickey button in. She also alleged staff A shoved the sharp end of a Q-Tip in the button. This statement was signed by Facility Nurse A and dated 8/8/19. Review on 8/22/19 of a medical evaluation for client #7 dated 4/10/19 revealed he is diagnosed with Severe Developmental Delays, Cerebellar Dystrophy, Vocal Cord Paralysis, Dysphagia and that he is non-ambulatory. Additional review of	W 154		

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the medical evaluation revealed he has trachesostomy and gastrostomy with a g-tube extension. The medical evaluation indicates that client #7 is to have no food or fluids by mouth (NPO).

Interview on 8/22/19 with Facility Nurse A revealed she had approached the Director of Nursing with concerns about staff A interfering with her replacing a Mickey Button for client #7. She stated she gave a written statement on 8/8/19 of these allegations to the Director of Nursing.

Interview on 8/22/19 with staff A revealed she had been assisting with client #7's bath on 8/7/19 when his Mickey Button came out of gastrostomy. She stated she contacted Facility Nurse A to assist her with putting the Mickey Button back into the Gastrostomy. Additional interview revealed facility nurse A tried more than once and was having difficulty. Staff A stated she had watched the Nurses several times reinsert the Mickey button for client #7. She stated that she tried to assist the Nurse and took the Mickey button away from her. She stated Nurse A was very upset but Nurse A was able to replace the Mickey Button. Staff A then asked the surveyor," What did she [The Nurse] tell you that I did? Why would she tell on me when I was trying to help her?" When asked if the DON had interviewed her about these allegations, she stated, "No."

Interview on 8/22/19 with the Director of Nursing revealed she had received allegations involving client #7 on 8/7/19 involving his Mickey Button being pulled out and staff A trying to reinsert his Mickey Button and poking a Q-Tip into client #7's gastrostomy. The DON stated these allegations

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had not been investigated. When asked if she had told the administrator about the allegations, she stated the administrator was away from work for several days and she did not contact her. Additional interview confirmed these allegations were also not reported to Health Care Personnel Registry. The DON stated she had held onto these allegations and asked facility Nurse A to come to her office to talk with her on 8/12 and 8/13. However, Facility Nurse A did not come to her office. The DON stated she had not interviewed staff A or any other staff in the area following this incident on 8/7/19.

Review of the facility's policy revealed, "The Administrator/Designee will begin each investigation within 24 hours of an allegation of abuse, neglect, exploitation, or any injury of unknown origin. The investigator will determine if the staff member alleged to have committed the act of abuse should be suspended immediately for the duration of the investigation, or if clinical supervision is needed in lieu of suspension, and take necessary action to assure the safety of all people involved."

Additional review of facility policy (102.052) revealed, "Neglect is generally defined as the failure to provide services and supports necessary to protect a person from serious and/or psychological harm. Unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk of harm."

Interview via phone on 8/22/19 with the Director of Operations for the facility confirmed the

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allegations involving client #7 and facility Nurse A on 8/7/19 were not reported to him. Additional interview revealed these allegations should have been thoroughly investigated by management per their company policy (102.52) to determine whether there may have been possible harm to client #7 or other clients in the facility.

Further interview on 8/23/19 confirmed facility management made the decision to to suspend the Director of Nursing, direct care staff A and Facility Nurse A on 8/22/19 upon learning of these allegations until the allegations could be further investigated.

B. Management failed to investigate allegations that direct care staff were putting four clients to bed on Friday afternoon and leaving them until Monday morning.

Review on 8/22/19 of a written statement dated 8/8/19 from facility Nurse A to the Director of Nursing revealed the following allegations:

1. Direct care staff (staff A, staff F and staff G) put clients #6, #20, #24, #29 to bed on 8/7/19 following their return from the school building around 3pm until Saturday 8/8/19 around 7-9am.

2. Direct care staff (staff A, staff F and staff G) were putting clients #6, #20, #24, #29 to bed on Fridays at 3pm when they returned from school and leaving them in their beds until Monday around 7-9am.

Interview on 8/22/19 with the Director of Nursing confirmed these allegations were not investigated.

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W 154	Continued From page 9 Interview on 8/23/19 with the Administrator and the Director of Operations confirmed these allegations were not investigated by management. The Director of Nursing failed to report several allegations of mistreatment to clients and a thorough investigation of these allegations was not completed by management. Subsequently, this resulted in the facility's systemic failure to provide statutorily mandated Client Protections to clients in the facility.	W 154		
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 observation, record review and interviews the facility failed to provide ongoing training to direct care staff specifically involving safely assisting clients during transfers. This affected 1 of 5 sampled clients (#13). The finding is: Direct care staff failed to follow guidelines for safely transferring clients. During observations on 8/22/19 in classroom 3 at the school, staff F took client #13 out of his chair used for mealtime and assisted him to the floor. Direct care staff put her arm around client #13's back and slid him out of his chair onto the floor into a crawling position on the floor of the	W 189		

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classroom. The seatbelt in client #13's chair was unfastened. The qualified intellectual disabilities professional (QIDP) was immediately asked if client #13 requires a one person transfer. The QIDP stated one person can transfer client #13 but it requires both hands because client #13 often tries to turn and get out of his chair as he is transferred. Further interview confirmed client #13 will attempt to unfasten his seatbelt.

Review on 8/22/19 of client #13's record revealed he has the following diagnoses: Bronchopulmonary dysplasia, chronic lung disease, tracheostomy with moderate intellectual disability and that he is considered non-ambulatory. Further review of his individual program plan (IPP) dated 4/4/19 confirmed client #13 is showing more independence towards mobility but requires a one person transfer during transfers out of bed, to his chair and onto the floor to crawl.

Interview on 8/22/19 with staff B revealed direct support staff on the afternoon shift often feel overwhelmed by responsibilities and sometimes do not always wait for another staff to assist clients that require two person transfers. She stated she has witnessed direct care staff transferring clients alone that are designated as 2 person transfers. She stated Nursing staff are often busy administering medications, setting up enteral feedings and caring for clients who require assistance with ventilators, tracheostomies and gastrostomies.

Interview on 8/22/19 with staff D revealed direct care staff are not always consistent following transfer guidelines for clients. She stated several direct care staff are transitioning to Nurses Aide II

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W 189	Continued From page 11 positions and need additional assistance with learning specific tasks. She stated the additional training that is needed is not always available and that staff try to transfer clients without asking for additional assistance. Interview on 8/23/19 with the Administrator revealed direct care staff had not reported problems with staff not consistently following transferring guidelines.	W 189		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 5 sampled clients (#7) relative to training staff in care of client's gastrosomy tubes. The findings are: Nursing services failed to retrain staff on the care of client #7's gastrostomy tubes after a problem was identified. Review on 8/22/19 of written allegations from Facility Nurse A to the Director of Nursing (DON) dated 8/8/19 alleged during client #7's bath on 8/7/19 his Mickey button was pulled out. When the Facility Nurse A tried to insert the Mickey Button, staff A took it out of the Nurse's hand and said, " I'll do it." Nurse A took the button back and reinserted it. Nurse A also alleged that staff A poked around in client #7's gastrostomy trying to jab the Mickey button in. She also alleged she	W 331		

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shoved the sharp end of a Q-Tip in the button. This statement was signed by Facility Nurse A and dated 8/8/19.

Review on 8/22/19 of a medical evaluation for client #7 dated 4/10/19 revealed he has Severe Developmental Delays, Cerebellar Dystrophy, Vocal Cord Paralysis, Dysphagia and is non-ambulatory. Additional review of the medical evaluation revealed he has trachesostomy and gastrostomy with a g-tube extension. The medical evaluation indicates that client #7 is to have no food or fluids by mouth (NPO).

Interview with the DON on 8/22/19 and with the Administrator on 8/23/19 confirmed additional training may be needed regarding client #7's specific care relative to his gastrostomy. Additional interview revealed no additional training has been provided to staff A, other direct support professionals and Nursing staff working with client #7 after the incident on 8/7/19 when his Mickey button became displaced after bathing.