PRINTED: 09/27/2019
FORM APPROVED
OMB NO. 0938-0391

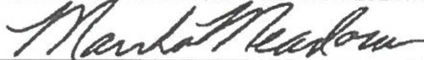
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	C 09/26/2019

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 000	INITIAL COMMENTS A complaint survey was conducted at the facility on 9/26/19. A deficiency was cited as a result of the complaint survey for intake #NC00155994.	W 000		
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 record review and interviews, the facility failed to ensure all allegations were thoroughly investigated. This affected 1 of 2 audit clients (#2). The finding is: An injury of unknown origin involving client #2 was not thoroughly investigated. Review of a facility investigation dated 9/3/19 revealed on the morning of 8/28/19 while helping client #2 with his shower, "when [Client #2] undressed, she noticed two bruises, in the shape of a straight line, about one inch long." Additional review of the report noted the staff reported the bruises immediately and the client was assessed by a nurse with no treatment needed. The investigation indicated on 9/3/19, the guardian was notified about the bruises by the Division Director and was concerned and wanted the bruises to be investigated because he suspected "somebody hit [Client #2]". Further review of the investigation report revealed an investigation into the bruises to client #2 began on 9/3/19 based on the concerns from his guardian. Continued review of the report noted	W 154	The investigatory process will be reviewed to include specific instructions on how to conduct thorough investigations. Training will be implemented with all managers with emphasis on how to identify those staff possibly having knowledge of an event and the responsibility of managers to conduct interviews and collect statements. Director of Advocacy will review investigatory process of alleged violations with advocates with emphasis on ensuring those staff possibly having knowledge of an event are interviewed and statements collected. RECEIVED OCT 08 2019 DHSR-MH Licensure Sect	11/15/19

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



TITLE: Center Director

(X6) DATE: 10/8/2019

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 154	Continued From page 1 the client requires one-on-one staff supervision/monitoring throughout his day and 15 minute bed checks at night. The report included one written statement from the staff who originally discovered the bruises on 8/28/19. Although client #2's 8/27/19 staff assignment sheet indicated at least four different staff had been assigned to him that day, no written statements or interviews from these staff members were included in the facility's investigation. Interview on 9/26/19 with the Home Manager and Division Director revealed client #2's one-on-one staff person is rotated about every 2 hours between various staff on a shift and three or more different staff could be assigned to him on a given shift. Additional interview confirmed the staff assigned to client #2 prior to the morning of 8/28/19 had not been interviewed during the investigation. Interview on 9/26/19 with the Director of Advocacy Services confirmed client #2's one-on-one staff should have been interviewed during the investigation.	W 154		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
KODY KINSLEY • Deputy Secretary for Behavioral Health & IDD
HELEN WOLSTENHOLME • DSOHF Director
MARSHA MEADOWS • Center Director

October 8, 2019

Ms. Wilma Worsley-Diggs, Facility Compliance Consultant I
North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Complaint Survey – Conducted September 26, 2019

Dear Ms. Worsley-Diggs:

On behalf of Caswell Developmental Center staff, I would like to thank your team for a thorough survey. Enclosed you will find the Statement of Deficiencies Form (CMS-2567) reflecting the Plan of Correction for each cited deficiency. We feel that this plan represents a comprehensive center-wide commitment to further increasing the quality of services for our individuals. I hope that you will find it to be acceptable. We look forward to your follow-up visit.

Please let me know if you have any questions regarding any of our responses.

Sincerely,

Marsha Meadows

Marsha Meadows
Center Director

MM/jh

Enclosure