STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G003	A. BUILDING ______ B. WING ______	C 06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J. IVERSON RIDDLE DEVELOPMENTAL CENTER	**300 ENOLA ROAD** **MORGANTON, NC 28655**

(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 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to implement it's policies and procedures to prevent neglect for 1 of 1 sampled client (#1). The finding is: Review of facility investigations on 6/25/21 revealed an investigation into the death of client #1 dated 6/12/21. Review of the internal investigation report, substantiated by interview with management staff and video recordings, revealed on 6/12/21 client #1 spend the afternoon with staff and peers as per her routine. The client was noted to have transfers of supervision to various staff at different times in the afternoon including when the client was conducting chores, walking to get afternoon medications, walking to dinner and during the dinner meal. Observation of staff transfers during times of client #1's transitions were observed to be informal and conducted among staff without a consistent protocol. Further reviews and interviews revealed the client to eat a small portion of her dinner, put away her place setting from dinner in the bin independently and then stand near the couch in the dining room area. Interview with staff revealed sitting or waiting by the couch was a usual process for client #1 and her peers, as clients usually would wait for a group to return back to the dayroom on the unit or other activity. Continued review of the investigation, interviews	W 149		

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.

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and video review revealed client #1 was standing beside the couch in the dining room before casually sitting down in the floor and taking off her shoes and socks. The client then casually stood up, walked out of the dining room and back onto the unit without being seen by the multiple staff in dining room who were all engaged in finishing up dinner and helping clients. Subsequent review, interview and video review revealed the client to walk out of the dining room, down the hall, around the corner and straight into the bathroom with the bathtub, unwitnessed by staff. No staff were noted to be in the hallway until staff began looking for the client and found client #1 unresponsive in a bathtub. Staff immediately removed the client from the tub to begin CPR while calling 911. Staff continued CPR until emergency personnel arrived and CPR was continued for a period of time but was unsuccessful and the client was pronounced dead at the scene.

Review of records for client #1 on 6/25/20 revealed the client to have a habilitation plan dated 9/21/20 that included a behavior support plan (BSP) which included self-injurious behavior. Further review of the BSP revealed the client's behavior would include picking at a wound area which would keep it from healing and often resulted in the client needing health-related protection plans to assist with healing with any wounds. Interview with management staff, substantiated by record review, revealed client #1 had a health-related protection plan in place on 6/12/21 for line of sight supervision due to the client's recent cataract surgery.

Further review of client #1's habilitation plan revealed the client to have a diagnosis of severe intellectual disability, possible autism and a

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history of a seizure disorder. Continued review of the habilitation plan revealed the client liked to take a bath to relax and had most skills required to complete bathing independently or with verbal prompts from staff.

Review of internal facility policy 2.2.11 Supervision of Resident Safety revealed the transfer of staff responsibility should occur by actual direct communication between the staff member transferring the resident and the staff who is to accept responsibility for the resident. Review of the facility's internal abuse, neglect and exploitation policy 2.3.3 Protecting Residents from Rights Infringements defines neglect as the failure to provide care or services necessary to maintain the mental and physical health of the resident.

Review of the advocacy investigation dated 6/12/21, initiated by the internal advocacy office, revealed an investigation was initiated upon report of a resident who required eyesight supervision was found deceased after the resident was found in a bathtub. A review of findings from the internal advocacy investigation revealed on the evening of 6/12/21 client #1 was without supervision for a period of 34 minutes despite required line of sight supervision guidelines. Further review of the report findings revealed a substantiated finding of neglect based on the facility's lack of safeguards for maintaining client #1's required level of supervision. Interview with facility administration on 6/25/21 verified the facility had failed to protect client #1 and had neglected to ensure the client's safety with proper supervision. While the specific timeline of events that occurred in the bathroom prior to client #1's death are unknown, inadequate supervision

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W 149	Continued From page 3 contributed to the client's death on 6/12/21. Interview with the facility administrator on 6/25/21 revealed corrective measures self-initiated by the facility since the 6/12/21 death of client #1 to include: identifying all clients on campus with special monitoring needs and conducting facility wide training with all staff regarding all supervision protocols for these clients, implementing a change in the process of client supervision transfers among staff to include a physical lanyard that stays with the responsible staff person to note their client's increased supervision needs. In addition, administration is currently exploring ways to increase the reliability of supervision monitoring across the facility campus staff and reviewing supervision protocols from a systems approach to assess further improvements to implementing supervision of clients.	W 149		