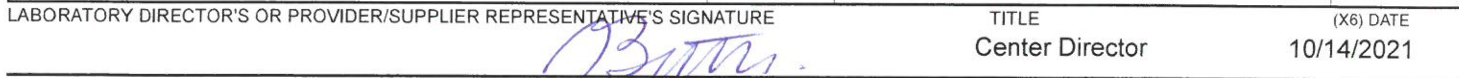
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2021
FORM APPROVED
OMB NO. 0938-0391

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 ______	09/29/2021

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 recertification, complaint and revisit survey was completed on 9/29/2021. All deficiencies have been corrected as a result of the revisit. As a result of the complaint survey, the complaint was substantiated for intake #NC00181238. A deficiency was cited in relation to the allegation. Deficiencies were also cited during the recertification survey.	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, record reviews and interviews, the facility failed to ensure all clients had the right to consume meals in group settings along with their peers and were not restricted based on their vaccination status. This affected 3 of 17 audit clients (#14, #15 and #16). The findings are: A. During mealtime observations in 102 Kendall on 9/28 - 9/29/21, nine clients residing in the home ate their meals in groups with prompting and assistance from various staff. Once the nine clients had finished their meals (approximately 50 minutes to 1 hour later), staff prompted or retrieved client #15 and client #16 to come to the dining room for their meal. Client #15 and client #16 consistently consumed their meals last and were not encouraged or assisted to eat along with any other clients in the home.	W 125	All clients residing in the facility will have the right to dine in group settings along with their peers regardless of their vaccination status. Weekly observations will be conducted to ensure clients rights are not restricted during dining while maintaining social distancing in all residential homes using the Quality Improvement Dining Audit Tool by either the HM, DS I or Home Teacher.	11/1/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Center Director	10/14/2021

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.

DHSR - Mental Health
OCT 20 2021
Lic. & Cert. Section

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W 125	Continued From page 1	W 125		

Interview on 9/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #15 and client #16 are the only two clients in the home who are not vaccinated against the COVID-19 virus. Additional interview indicated as directed from upper management, unvaccinated clients are not allowed to eat meals with vaccinated clients in their home. The QIDP acknowledged it was not entirely understood why the unvaccinated clients could not eat with vaccinated clients since all of the clients consistently interact with each other in various areas of the home environment.

Review of an email from the Director of Education dated 6/4/21 noted, "The residents who have been fully vaccinated can resume eating as a group at all meals. Those residents who have not been vaccinated must continue to dine using social/physical distancing. As this practice has not been occurring for some period of time, it may take some time for the adjustment back to dining together. Staff, supervisors, and team members should work together to assist with the movement back to dining together as a group and resolve issues as they arise."

Review on 9/28/21 of client #15's Individual Program Plan (IPP) dated 4/26/21 revealed, "[Client #15] does not understand most of his rights and continues to require assistance from his guardian as well as staff to ensure that his rights are protected...He does not fully understand his rights or the concept of his rights."

Review on 9/28/21 of client #16's IPP dated 7/1/21 revealed, "[Client #16's] rights were reviewed with him. When the rights were

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W 125	Continued From page 2	W 125		

explained to him, he seemed to understand many of his rights and has demonstrated the ability to exercise them independently. He also understands that there are responsibilities associated with his rights, although he does have some difficulty adhering to some rules..."

Interview on 9/29/21 with the Director of Standards Management indicated unvaccinated clients should not be restricted from eating with vaccinated clients in the home. However, they should still maintain social distancing.

B. During observations in 102 Byrum on 9/27/21 at 4:40pm, client #14 was observed eating dinner alone with no other clients in the dining room.

Interview on 9/27/21 with Staff H revealed client #14 dines alone as he is unvaccinated against COVID-19, so therefore he cannot eat with his peers.

Interview on 9/28/21 with the QIDP revealed client #14 is the only client in the home that is unvaccinated, so he eats his meals alone in the dining room before his peers eat together.

Review of an email from the Director of Education dated 6/4/21 noted, "The residents who have been fully vaccinated can resume eating as a group at all meals. Those residents who have not been vaccinated must continue to dine using social/physical distancing. As this practice has not been occurring for some period of time, it may take some time for the adjustment back to dining together. Staff, supervisors, and team members should work together to assist with the movement back to dining together as a group and resolve

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W 125	Continued From page 3 issues as they arise." Interview on 9/29/21 with the Director of Standards Management indicated unvaccinated clients should not be restricted from eating with vaccinated clients in the home. However, they should still maintain social distancing.	W 125		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure nursing staff were sufficiently trained to implement emergency medical protocols and document on the Medication Administration Record (MAR). This affected 2 of 17 audit clients (#2 and #12). The findings are: A. During observations of medication administration in 102 Kendall on 9/27/21 at 11:26am, as client #2 placed his pills into a medication cup, Nurse A initialed the MAR for the two pills prior to their ingestion. Immediate interview with Nurse A revealed she routinely initials the MAR in advance for clients who generally take their medication without any problems.	W 340		

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W 340	Continued From page 4 Review on 9/28/21 of the facility's Medication Preparation, Administration and Documentation (effective 10/16/20) revealed, "The MAR is initialed immediately after medications are administered and prior to the administration of the next resident's medications. Document only after observing the resident take the medication(s)." Interview on 9/28/21 with the Nursing Supervisor confirmed the nurse should not sign the MAR prior to the client ingesting his medications. B. Review on 9/28/21 of client #12's medical progress notes dated 9/8/21 revealed at 2:50am, Nurse B received a call from Alpha cottage staff, client #12 was having difficulty breathing. When assessed, Nurse B found client #12 gasping for air, making gurgling sounds and pale in color as well as cool to touch. Nurse B attempted several times to get vitals from client #12 unsuccessfully. Nurse B phoned Nurse C to ask for assistance with client #12. Client #12 was placed on oxygen and suctioned with little results. Nurse B then called the physician's assistant to report that she was calling 911 to send client #12 out to the hospital. Review on 9/28/21 of the Dr. Red Summary, written by Nurse B on 9/8/21 identified the following details. Nurse B suctioned client #12 at 3:00am. At 3:10am, Nurse B became the lead nurse in his care and administered oxygen at 3:15am. At 3:20am, Nurse B contacted 911 for ambulance transport. The ambulance arrived at 3:35am. Client #12 died at 5:14am at the hospital. Review on 9/28/21 of the facility's policy on Medical Emergencies dated 9/1/20 it read the	W 340		

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W 340	Continued From page 5 purpose was to ensure a prompt, collective response to medical emergency situations. 1. "Dr. Red" is called when a serious medical emergency or life-threatening situations arises, staff on the scene will immediately assess the involved person (is there presence or respirations or pulse?) and call #3444 and state the nature of the emergency and the location...3. 911 is to be called by the staff at the location if the person is not breathing, does not have a pulse or has a significant injury. Interview on 9/27/21 with the Unit Nurse Supervisor of Rolling Hills (Nurse D) revealed that she was responsible for training nurses on her unit. Nurse D stated that last month, the facility implemented a Residential Living Nurse (RLN) system to provide coverage for cottages for medical emergencies. Nurse D stated that staff have been informed that once a "Dr. Red" is called, the nurse who comes to the location to assist, handles the client while the nurse who initiated the "Dr. Red" proceeds to call 911. Nurse D further stated it was the responsibility of the RLN to make the judgment call to send the client out. Interview on 9/28/21 with Nurse B acknowledged that she worked overnight on 9/7/21-9/8/21. Nurse B said she received a "Dr. Red" call around 3:00am to go to Alpha cottage to assess client #12 who was having breathing problems. Upon arrival, Nurse B found client #12 to be in respiratory distress and tried several times to get his vitals signs, but they were not registering on the equipment used. Nurse B decided to call for back up help to secure client #12's vitals. Nurse B said that Nurse C arrived about 15 minutes after	W 340	Facility Nursing Staff will ensure all staff at the facility are sufficiently trained to implement emergency medical protocols by revising procedures for the Caswell Center Nursing Manual through documentation on the Staff Development Training Roll. Facility Nursing Services will ensure all new hire and agency nursing staff are sufficiently trained in documentation procedures on the Medication Administration Record (MAR). Training for documentation on the MAR will be documented on the Staff Development Training Roll. Weekly observations and audits per area will be completed by either the RNS II, RNS III, RN Consultant or RN Director to ensure compliance for appropriate documentation of the MAR.	11/1/2021

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W 340	Continued From page 6 Nurse B and took over client #12's care. Nurse B said that she then began to prepare the paperwork to send with EMS because once she calls 911, the ambulance would arrive quickly. While working on the paperwork, Nurse B acknowledged that she made a call to the Physician Assistant (PA #1) that she thought was on call. Nurse B stated that PA #2 responded to the call, after speaking with PA #1. Nurse B notified the PA#2 that she had already made the decision to send client #12 since "you don't play with ABC." Nurse B was asked to clarify what ABC stood for and she replied "airway, breathing and circulation." Nurse B stated that she called 911 maybe 30 minutes after her arrival, when client #12's condition did not improve. Interview on 9/28/21 with the Director of Nursing (DON) revealed that each nurse supervisor was responsible for doing their own training, on whatever they thought was important for the nurses. The DON stated that all staff received a memo on 8/10/21, sent by email on the new RLN policy. The DON acknowledged that the facility did not have a policy on how often nurses needed to receive training however the facility's nurse consultant had the responsibilities to monitor the training that nurses received.	W 340		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review and	W 382		

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W 382	Continued From page 7 interviews, the facility failed to ensure all medications were kept locked except when being administered. The finding is: During observations in 102 Kendall on 9/27/21 from 11:37am - 11:39am, the medication cart was unlocked. During this time, Nurse A was in a client's bedroom assisting him to take his medications. For approximately 2 minutes, the medication cart was unlocked, unattended and drugs were accessible to anyone in the home. Immediate interview with Nurse A confirmed the medication cart was left unlocked and unattended. Review on 9/28/21 of the facility's policy regarding Medication, Preparation, Administration and Documentation (effective 10/16/20) revealed, "Do not leave medication cart unattended unless it is locked." Interview on 9/28/21 with the Nursing Supervisor confirmed the medication cart should not be left unlocked and unattended by the nurse.	W 382	The facility will ensure all medications are kept locked except when being administered. All new hire and agency nurses will be inserviced on proper drug storage and recordkeeping. Training for these staff will be documented on the Staff Development Training Roll. Weekly observations and audits per area will be completed by either the RNS II, RNS III, RN Consultant or RN Director to ensure compliance of proper drug storage.	11/1/2021
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436		

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W 436	Continued From page 8 Based on observations, record review and interview, the facility failed to ensure client #13 was taught to use and make informed choices about the use of her hearing aid. This affected 1 of 17 audit clients. The finding is: During observations in 101 Byrum throughout the survey on 9/27 - 9/28/21, client #13 did not wear a hearing aid. Client #13 was not prompted or encouraged to wear her hearing aid. Review on 9/27/21 of client #13's Individual Program Plan (IPP) dated 8/12/21 revealed client #13's hearing is borderline normal for the reception of speech in her right ear and a profound loss in the left, and utilizes a hearing aid for her right ear. Interview on 9/28/21 with Staff E revealed client #13 is supposed to wear a hearing aid in her right ear. Interview on 9/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #13 should be wearing a hearing aid in her right ear and staff should prompt her to wear her hearing aid.	W 436	Teams throughout the facility will ensure training is implemented as needed for residents regarding choice making and/or usage of personal support devices, such as glasses, hearing and other communication aids, braces and other devices identified by the interdisciplinary team. Teams will complete a personals checklist audit for residents with identified personal support devices and indicate, implement and document recommended training needs in the resident's Life Plan.	11/15/2021

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
KODY KINSLEY • Chief Deputy Secretary for Health
KAREN BURKES • DSOHF Director
STAN BUTKUS • Center Director

October 14, 2021

Ms. Lesa Williams, Facility Compliance Consultant II
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: Recertification Survey – Conducted September 27-29, 2021

Dear Ms. Williams:

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,

Stan Butkus
Center Director

SB/jh

Enclosure