STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**140 PIRATES ROAD NEW BERN, NC 28562**

(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 completed on 4/7/22 for intakes #NC00187003, #NC00187343 and #NC00187466. The intakes were substantiated. Deficiencies were cited.	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 9 audits clients (#1 and #6) received a continuous active treatment program consisted of needed interventions and services identified in the individual program plan (IPP) in the area of supervision. The findings are: A. During morning observations on 4/7/22 at 6:48am, staff B sat in a chair in the doorway of client #6's room, while he was in bed. At 7:10am, staff B left her post and went to the nurse's station at the end of the hall to use the computer. Unable, to find what she needed, staff B left the unit. The chair where staff B sat, remained unoccupied in the doorway of client #6's room. At 7:30am, client #6 was observed awake, sitting up in bed; no staff was visually supervising him.	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**140 PIRATES ROAD NEW BERN, NC 28562**

(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 249	Continued From page 1 Review on 4/7/22 of client #6's IPP dated 1/27/22 revealed staff were advised he was an elopement risk and required close monitoring at all times. Client #6 should remain in staff's direct line of vision. An additional review of training on 3/9/22 emphasized if client #6 wakes early, provide activities to do; if he is restless, staff are immediately to notify or obtain additional staff for standby. Staff should know where their supported clients are at all times and have visual supervision on him at all times. Review on 4/7/22 of an incident report dated 1/16/22, revealed client #6 climbed out a window and entered the parking lot. At 7:58am, staff M found client #6 outside the door on B unit, banging on the glass. Staff N went outside and ran after client #6 and he willingly came back in the building. Client #6 was examined and had a cut on his left finger. Review on 4/7/22 of an incident report dated 3/8/22 , revealed client #6 was supposed to be supervised by staff L, who left his assigned area for undetermined amount of time during third shift, to check on another client. At 5:00am, the nurse went to client #6's room to give medication and noticed the client was missing. The top of his window was opened, which allowed client #6 to climb out of it and bypass the alarm on the window. Staff on the unit began to search for client #6, who was found approximately 10-15 minutes later in a separate building, at the greenhouse. The door to the greenhouse was unlocked and he entered the building. Client #6 was examined by the nurse and no injuries were detected. Staff assigned to client #6 on 3/8/22 were permanently removed from his assignment	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**140 PIRATES ROAD NEW BERN, NC 28562**

(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 249	Continued From page 2	W 249		

and client #6's room was moved down the hall, in the event of another elopement, staff could locate him quicker in a fenced area. An inservice was held on 3/9/22 with each staff attending acknowledging they had read his behavior support plan (BSP).

Interview on 4/7/22 with staff B revealed she was providing supervision to client #6 and in her role, she could not leave her assigned area unless she was on break. She had to ensure someone covered her assignment before she left the client.

B. During morning observations on 4/7/22 at 6:48am, staff A was sitting in a chair inside the doorway of client #1, who was in bed. At 7:10am, staff A stood up and moved to the narrow space between clients #1 and #6 rooms, after staff B left the hall. Staff A kept her back to the doorways as she interacted with other staff on the hall. At 7:25am, staff A was relieved by staff J who sat in the chair to start visually supervising client #1.

Review on 4/7/22 of client #1's IPP dated 7/6/21 revealed he required an assigned staff to continuously visually supervise him daily.

Interview on 4/7/22 with behavior specialist #1 (BSP#1) revealed both clients #1 and #6 are high elopement risks and must be visually supervised at all times, with eyes on them for every second. Staff must face and be near them while providing supervision. The BSP#1 stated it was not acceptable to have staff have their back to the client while supervising. The BSP#1 also stated that staff must document in a book who is relieving the assigned staff on break.

Interview on 4/7/22 with behavior specialist #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G017	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	140 PIRATES ROAD NEW BERN, NC 28562

(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 249	Continued From page 3 (BS#2) revealed all staff providing supervision must be trained and had to pass a behavior support plan (BSP) assessment test for client #6 on 3/9/22. The BSP#2 stated that client #6 should not have been left unsupervised this morning. BSP#2 stated staff A was assigned to provide 1:1 supervision for only client #1 and cannot attempt to cover both rooms by standing in the hall with her back to the doors. Interview on 4/7/22 with the director of resident services (DRS) stated staff providing supervision for a client do not carry other assignments, in order to permit them to continuously visually monitor the assigned client. The DRS stated staff have been trained on the BSP and have been trained to not leave their assignment without coverage.	W 249		