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	34G265	A. BUILDING _____ B. WING _____	C 06/08/2022

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W 000	INITIAL COMMENTS #NC00189682	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149); and ensure all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its clients.	W 122		
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 record reviews and interviews, the facility failed to ensure deceased client (dc #1) was not subject to unintentional neglect. The finding is: Review on 6/6/22 of the facility's investigation initiated on 5/9/22 revealed that dc #1 had a typical morning with no concerns noted and was placed in his bed at 1:30pm for a nap. At 2:50pm Staff A noted dc #1 to be waking up from his nap. At this time, Staff A left the room to get dc #1's afternoon snack. At 3:00pm Nurse 2 noted dc #1 to be cyanotic and unresponsive with	W 149		

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

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W 149	Continued From page 1 tracheostomy (trach) dislodged. It was noted by Respiratory Therapist 1 (RT 1) that the flange on dc #1's trach was broken as she was called to the bedside to assist. RT 1 replaced the trach and began cardiopulmonary resuscitation (CPR) at the bedside until Emergency Medical Services (EMS) arrived and assumed care. It was noted early in the day that dc # 1's trach was intact and in proper position by RT 1 as she performed his trach care that shift. It was determined that the trach dislodgment led to decompensation that required dc #1 to be hospitalized at the local Pediatric Intensive Care Unit (PICU) from 5/9/22 until 5/14/22. The investigation concluded that facility staff acted appropriately and swiftly to provide proper medical care at the discovery of the trach becoming dislodged as evidenced by the response they provided and the Return of Spontaneous Circulation (ROSC) status post resuscitative efforts. Review on 6/6/22 of the North Carolina Incident Response Improvement Systems (IRIS) report completed by the facility administrator on 5/16/22 revealed between 2:54pm and 2:55pm Staff A and Nurse 2 noted dc #1 to be awake and alert. Between 3:00pm to 3:05pm Nurse 2 noted dc #1 to be face down on his pillow with his pulse oximeter not picking up. Nurse 2 rolled dc #1 over and noted his lips were cyanotic and trach appeared to be out and on the side of his neck. Nurse 2 called RT 1 to the bedside to assist and trach was held in place by RT 1. RT 1 noted the left side flange to be broken at this time. Nurse 1 and Nurse 3 entered the room at this time and helped lower dc #1 to the floor and CPR was started as no pulse was detected. Nurse 1 called 911 and paged the administrator as well as the respiratory therapy manager (RTM) to the	W 149		

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W 149	Continued From page 2	W 149		

bedside. The administrator and RTM arrived at the bedside and took over compressions approximately 1 minute after CPR was initiated. RT 1 placed a new trach in stoma and secured trach ties. The administrator took over bagging and felt for a pulse but none was detected. He heard bilateral air movement with bagging. Shortly after EMS arrived and placed dc #1 on a cardiac monitor, initial reading had organized rhythm with heart rate in the 30's. EMS established IV access and epi drip was started. Heart rate improved and pulse was detected at approximately 3:17pm. CPR was stopped and dc #1 was transported to the hospital via EMS accompanied by RTM. Dc #1 was admitted to the local hospital until 5/14/22 when he passed away at 2:23pm.

Review on 6/6/22 of dc #1's Individualized Program Plan (IPP) dated 1/6/22 revealed no information related to client #1's required level of supervision.

Review on 6/6/22 of dc# 1's annual nursing evaluation dated 1/13/22 revealed "...has been very stable over many months but has very difficult airway necessitating ongoing close medical supervision. Attention to promoting development, addressing airway safety."

Further review on 6/6/22 of dc #1's annual respiratory evaluation dated 1/3/22 revealed dc #1 has history of decannulation with rapid decompensation, requiring CPR. It also reveals dc #1 has done well this year even when trach comes out and was able to alert staff without decompensation and trach was replaced without issue.

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W 149	Continued From page 3 Review on 6/8/22 of physician's orders dated 5/4/22 revealed orders for "pulse ox spot checks every 4 hours while awake and continuous checks while asleep with parameters set at SP02 100/92 and HR 140/60." In addition, an order to "instill normal saline into trach every 4 hours while awake, suction as needed at 12:00am, 4:00am, 8:00am, 12:00pm and 4:00pm." Dc #1 also has orders to "provide trach care with soap and water twice daily 7am-7pm and 7pm-7am." Review on 6/8/22 of facility's Accuflo system, dc #1 is to have wet/dry checks every 2 hours. Dc #1's last wet/dry check on 5/9/22 was at 12pm and there was no documentation that he was checked at 2pm as ordered. Dc #1's order for normal saline at 12pm was documented that it was given by Nurse 2 at 1:07pm. There was no documentation found that dc #1 had received pulse oximeter spot checks while awake at any time during the day on 5/9/22. There was also no documentation found that indicated pulse oximeter was placed on dc #1 prior to going down for his nap per physician orders to have oxygen monitored while sleeping. Nurse 2 documented in Therap on 5/9/22 at 9:48am that dc #1's trach was midline, secured with trach ties and intact. No documentation was found to support RT 1 provided trach care for dc #1 on 5/9/22 as reported in the facility's investigation. Interview on 6/8/22 with Nurse 2 revealed that her understanding is that someone should be in the room with the clients at all times. Nurse 2 reports she was assigned to bedrooms 3 and 4 which included dc #1 on 5/9/22. Further interview revealed that dc #1 always rips his pulse oximeter monitor off as soon as he wakes up and that he had done so on 5/9/22. Nurse 2 was in the	W 149		

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W 149	Continued From page 4	W 149		

adjacent room (Room #3) to dc #1's room (Room 4) when she was notified he was waking up and Staff A was leaving the room to get him a snack. Nurse 2 revealed she could not see dc #1's bed from where she was in room 3 but once she was done hanging feeding bags for other residents in room 3, she noticed dc #1's pulse oximeter monitor doing something unusual but it was not beeping. At that time she walked over to dc #1's bed and noticed him face down at the foot of the bed. Nurse 2 confirmed there was no documentation related to pulse oximeter being placed on client prior to his nap per physician's orders or pulse oximeter spot checks while awake for 5/9/22.

Nurse 2 also reports that on 5/8/22 dc #1's wall pulse oximeter machine was malfunctioning and a portable pulse ox machine was used. However, on 5/9/22 dc #1's wall pulse oximeter had been returned. Nurse 2 reports that dc #1's trach dislodges several times a week and he would scoot on his knees to staff with his trach in his hand to notify staff it was not in place. Nurse 2 reveals dc #1 was only alone in his bedroom for a few minutes from when Staff A left to get a snack and she entered the room.

Interview on 6/8/22 with administrator revealed the expectation is that clients are monitored around the clock with staff in the rooms at all times, and he was unaware of any issue with dc #1's wall hanging pulse oximeter on 5/8/22. He confirmed dc #1 should have the pulse oximeter monitor on while sleeping but was unable to locate documentation regarding it being in place, confirmed there was no documentation after 12pm for wet/dry checks for dc #1 and there was no documentation for RT 1 having performed

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W 149	Continued From page 5 trach care on dc #1 on 5/9/22. Further interview revealed administrator was unaware of dc #1's trach dislodging several times per week and there is never documentation completed at set intervals such as bed checks/sleeping logs or documentation throughout the day on clients activities. Review on 6/8/22 of the facility's NC/MH/IDD/SU Services Manual updated 3/30/22 revealed policy 102.05 Abuse, Neglect and Exploitation which defines neglect as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm. Further review of policy 102.05 revealed 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 for harm. The facility was notified by the surveyors on 6/8/22 that immediate jeopardy existed in the facility based on review of the facility's internal investigation, review of medical documentation and staff statements that showed no evidence existed to prove dc #1 received his necessary medical interventions leading up to dc #1 being found unresponsive. The facility responded with the following plan of protection actions: 1. In-service all staff on medical needs of children supported as well as policy and procedures for monitoring and providing support to each individual. 2. Additional trach care and monitoring with detailed description of care provided as well as	W 149		

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W 149	Continued From page 6 trach position, condition of site, and integrity of trach and trach ties. 3. In-service all staff on the need for proper documentation of all care provided, as well as ensuring all physician's orders are followed and documented appropriately. 4. Management staff will increase presence on the floor and do routine checks on documentation and monitoring daily, with documentation given to the administrator weekly. After reviewing the plan of protection developed by the facility on 6/8/22, it was determined the immediate jeopardy was removed.	W 149		
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 an incident of unintentional neglect was thoroughly investigated. This affected 1 deceased client (#1). The finding is: Review on 6/6/22 of the facility's investigation initiated on 5/9/22 revealed that dc #1 had a typical morning with no concerns noted and was placed in his bed at 1:30pm for a nap. At 2:50pm Staff A noted dc #1 to be waking up from his nap. At this time, Staff A left the room to get dc #1's afternoon snack. At 3:00pm Nurse 2 noted dc #1 to be cyanotic and unresponsive with trach dislodged. It was noted by Respiratory Therapist 1 (RT 1) that the flange on dc #1's trach was broken as she was called to the bedside to assist. RT 1 replaced the trach and began cardiopulmonary resuscitation (CPR) at the	W 154		

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W 154	Continued From page 7	W 154		

bedside until Emergency Medical Services (EMS) arrived and assumed care. It was noted early in the day that dc # 1's trach was intact and in proper position by RT 1 as she performed his trach care that shift. It was determined that the trach dislodgment led to decompensation that required dc #1 to be hospitalized at the local Pediatric Intensive Care Unit (PICU) from 5/9/22 until 5/14/22. The investigation concluded that facility staff acted appropriately and swiftly to provide proper medical care at the discovery of the trach becoming dislodged as evidenced by the response they provided and the Return of Spontaneous Circulation (ROSC) status post resuscitative efforts. The conclusion of the investigation did not address the period of time that dc #1 was left unattended from 2:50pm through 3:00pm, and did not address the issue that no documentation was available to show that dc #1 received his wet/dry checks at 2:00pm or documentation to show his pulse oximeter was connected at the time he was asleep.

Review on 6/8/22 of the facility's NC/MH/IDD/SU Services Manual updated 3/30/22 revealed policy 102.05 Abuse, Neglect and Exploitation which defines neglect as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm. Further review of policy 102.05 revealed 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 for harm. Continued review of the facility's policy revealed the facility has zero tolerance for intentional neglect or unintentional neglect that results in harm or significant risk of harm. Actions taken toward

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W 154	Continued From page 8 staff involved in incidents that occur due to an act of carelessness, omission, accident or distraction that results in no harm or risk to a person receiving services will be determined by management and may include disciplinary action up to and including termination. Interview on 6/8/22 with the facility administrator revealed that once the facility concluded their investigation, it was determined that the facility acted appropriately following the time when dc #1 was found unresponsive. The administrator stated that during the investigation, it was determined that dc #1 was left unattended for a period of approximately 10 minutes, but the investigative team did not look further into this issue. In addition, the administrator revealed that once the investigation was concluded, there were "mumbling's" amongst staff referencing dc #1 being unattended and unsupervised as well as not being hooked up to his pulse oximeter. The administrator confirmed the investigative team did not investigate these allegations nor did they investigate the issue that no documentation was available to show that dc #1 received his wet/dry checks at 2:00pm or documentation to show his pulse oximeter was connected at the time he was asleep. .	W 154		