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 05/24/2023

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

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W 000	INITIAL COMMENTS A revisit was conducted for all previous deficiencies cited on 4/6/23. All deficiencies were corrected. A complaint survey was also conducted for intakes #NC00201872, #NC00202134, #NC00202528, #NC00202531 and #NC00202773. The complaints were substantiated. Deficiencies were cited.	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: Based on record review and interview the facility failed to implement written policies and procedures that prohibit neglect of the clients (W149). The cumulative effect of these systemic practices resulted in the facility's failure 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 review and interview the facility failed to ensure written policies and procedures were implemented that prohibit neglect by maintaining appropriate supervision to meet client needs and maintaining client safety in the home. This affected 1 of 1 deceased client (dc #1). The	W 149		

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

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W 149	Continued From page 1	W 149		

finding is:

Review on 5/24/23 of the facility's incident report dated 5/20/23 revealed, staff B reported she and staff A transferred dc #1 from the wheelchair to a bed in the day room around 3:30pm. Staff B moved the wheelchair up to the bed and placed dc #1 on her back, partly on her right side. However, staff A reported she helped staff B put another person in a bed and then told staff B she needed to go get that person a change of clothes. Per staff A, she offered to help staff B transfer dc #1 to bed once she was finished with the other individual. Staff A stated she left the I-unit, went to the bedroom to get the clothes and then returned. When she returned, she noticed staff B had placed dc #1 in her bed without staff A's support. Staff B stated she changed dc #1's incontinence brief and positioned her face up with her head lying on a pillow. The head of her bed was slightly elevated and a body pillow was used for positioning. Staff A reported staff B did not put a pillowcase on the pillow nor remove the plastic. Staff A reported that she also did not remove the plastic wrap from the pillow when staff B failed to do so.

Continued review on 5/24/23 of the incident report dated 5/20/23 revealed, staff B went on break at 3:52pm and Staff A remained in the room with dc #1 and other people supported. Staff C reported at 4:30pm she walked into the I-unit, looked over at dc #1 and saw she was on her right-side and her face in the pillow. Staff C removed the pillow and saw blood in her nose. Staff B described dc #1 as being pale and diaphoretic. DC #1 did not respond to verbal or tactile stimulation. Staff D entered the room right after staff C and she went to dc #1's bedside, tapped her and called her

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W 149	Continued From page 2	W 149		

name. DC #1 did not respond. Staff C and staff D reported staff A was sitting on a red tabletop in the right corner of the room (facing the window) and was on her cellphone. Staff C told staff A to get the nurse. Staff D reported staff A remained in the corner of the room not doing anything, until staff C yelled to hurry up. The facility's Licensed Practical Nurse (LPN) entered the room and saw dc #1 laying on her back, skin was moist and pale. Blood was coming from the right nostril and was without a pulse and respirations. The LPN began CPR. Staff provided CPR until EMS arrived. EMS transferred dc #1 to the local hospital "where she succumbed to her event." DC #1 was pronounced dead at 5:17pm.

Review on 5/24/23 of dc #1's record revealed an Individual Program Plan (IPP) dated 7/21/23 with diagnoses of Profound IDD, Cerebral Palsy, Spastic Quadriplegia, Static Encephalopathy; Flexion Contractures, Scoliosis, Right hip dislocation, GERD, Seizure Disorder, Anemia, Osteopenia. Dc #1 communicates wants and needs, pleasure and displeasure through eye gazes, changes in facial expression and vocalizations. She needs full support from staff with all ADLs. Due to osteopenia it is important that two staff assist with all transfers, repositioning, dressing, bathing and toileting.

Further review on 5/24/23 of dc #1's record revealed an occupational evaluation dated 7/20/22 stating dc #1 is dependent on staff for all of her repositioning needs. Her out of WC positioning option is on a hospital bed to ensure her safety. Due to history of GERD her head of bed should be elevated as well whenever she is positioned on hospital bed.

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W 149	Continued From page 3	W 149		

Interview on 5/24/23 with LPN revealed she was working the day of the incident. Staff A walked up to the station and said dc #1 was unresponsive. When she arrive to the room, dc #1 was laying on bed on her back. Her skin was pale and moist. She also had a bit of bright red blood out right nostril. She assessed for pulse but there wasn't one. She sent the med tech to check to make sure dc #1 wasn't a DNR. She started CPR after 30 seconds. While she was doing CPR, she asked staff A what happened. They stated they moved the pillow from the bed to the floor. She looked down and the long body pillow was on the floor with the plastic on it. Dc #1 had a regular pillow behind her head. Staff continued CPR until EMS arrived. The day after the incident, she checked all of the pillows to remove anything with plastic.

Interview on 5/24/23 with staff E revealed since the incident with dc #1, management had staff review an inservice regarding removing the plastic from clients pillows. However, no other trainings or information had been provided.

Interview on 5/24/23 with Administrator revealed dc #1 was total care and dependent on staff for repositioning. She was unable to move independently and required 2 person transfers. During the investigation, they learned that Staff A was left alone with 9 other clients while staff B went on break. She didn't believe this was the norm for staff to client ratio. The facility protocol is that staff notify the charge person so they can have another staff cover, however, this did not occur. It is unclear whether or not staff transferred dc #1 independently or with assistance because they have been told 3 different stories from staff. Staff did say that dc

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W 149	Continued From page 4 #1 was found laying with her face in the body pillow which still had plastic on it and no pillow case. The plastic should have been removed. They also learned that staff A was on her cellphone while in the room with the clients which is also against facility policy. Continued interview on 5/24/23 with the Administrator revealed the facility's internal investigation concluded staff neglect. Staff A and B were suspended. The committee recommendation is termination. The facility is currently working on a safety plan to provide to the MCO (Managed Care Organization). They had already inserviced the housekeepers on removing all plastic from pillows and mattresses. They have removed the plastic from the pillowcases but not all of the mattresses. They are planning to add this into the checklist as part of training for new housekeepers. The Administrator stated she is scheduled to meet with the Occupational Therapist to review and develop formal repositioning guidelines for non-ambulatory clients needing out of wheelchair time throughout the day. The Administrator confirmed there is still a lot that has to be done in relation to the investigation. Review on 5/24/23 of the facility's policy on definition of Neglect (dated 12/22) revealed, "Neglect is generally defined as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm." The policy further states "because an allegation of neglect may be substantiated for an intentional...staff action, delineation of the degree of seriousness is required to determine the most appropriate level of disciplinary action warranted. this definition is	W 149		

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W 149	Continued From page 5 defined as follows: 1. 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 found to be neglectful in that on 5/20/23 they failed to provide adequate staff to client ratio. Staff B transferred dc #1 without supports as identified in her IPP and then left the room at 3:52pm to go on break, leaving Staff A alone in the day room with 9 clients. Staff B failed to alert the charge person that she was going on break so that additional staff could cover. While being left alone in the day room, staff A failed to provide supervision to dc #1. Dc #1 was found lying with the right side of her face in a body pillow, in which the plastic had not been removed. Staff A was noted to be on her cellphone when other staff arrived in the room at 4:30pm. Dc #1 was found unresponsive, pale and moist to touch by another staff member. CPR was performed by nursing staff however dc #1 was pronounced dead at 5:17pm. These systematic failures resulted in neglect and the Condition of Participation in Client Protection was found to be out of compliance.	W 149		