DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY IPLETED
34		34G001	B. WING		06	C 5/29/2023
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CASWELL	CENTER			2415 W. VERNON AVENUE KINSTON, NC 28501		
()(4) (D			ID	PROVIDER'S PLAN OF COR		(YE)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		W 00	0		
W 249	intake #NC00202772 substantiated. Deficit the complaint allegati PROGRAM IMPLEMI CFR(s): 483.440(d)(1 As soon as the interd formulated a client's i each client must rece treatment program co interventions and serv and frequency to sup	ences were cited related to ons. ENTATION) isciplinary team has ndividual program plan, ive a continuous active	W 24	9		
	This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure client #1's individual program plans (IPP) was consistently implemented in the area of behavior intervention. This affected 1 of 1 audit client (#1) residing in Parrott 102. The finding is: Review on 6/29/23 of client #1's IPP dated 4/6/23 revealed client #1 has Mild Intellectual Disabilities, Schizoaffective Disorder, Bipolar Type and has several target behaviors which included: physical aggression, self-injurious behavior (SIB), threats of self harm, ingestion related SIB, property destruction, task related avoidance and non-compliance, verbal aggression, false allegations and inappropriate telephone use.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 06/30/2023

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.

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/30/2023 MAPPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED		
		34G001	B. WING_			_		C 29/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				24	415 W. VERNON AVENUE			
CASWELL	CENTER			ĸ	INSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	program (BSP) dated following target behavior ingestion related SIB, related avoidance and aggression, false alleg telephone use requirin interventions. The res- include: restricting his belongings in a locked television and remote unit and 2:1 supervision daily room checks of I belongings three time on room search and s- review of the BSP rev- may have swallowed notified immediately a supervision which req around the clock until the inedible item. Observations in Parm 12:15pm revealed clies supervision in his livin Observations of his be closet was locked, his covered in Plexiglass. Interview on 6/29/23 of client #1 receives 1:1 and also has crisis su allegations or direct ca have swallowed an in interview confirmed en the leisure activity cer- taking the television re-	client #1's behavior support 10/11/22 revealed the fors of: physical aggression, (SIB), threats of self harm, property destruction, task a non-compliance, verbal gations and inappropriate ng several restrictive trictive interventions clothing and personal d closet, plexiglass over his , 1:1 supervision in his living on outside the living unit, his room and personal s daily that is documented eizure forms. Additional ealed if staff suspect client an inedible item, nursing is nd he is placed on crisis uires 2:1 supervision it is verified he has passed out 102 on 6/29/23 at ent #1 was receiving 1:1 g unit from staff B. edroom area revealed his television and remote were with Nurse A confirmed supervision in his living unit pervision if he makes are staff suspect he may	W	249				

Facility ID: 955755

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/30/2023 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
34G		34G001	B. WING			C 06/29/2023		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CASWELL CENTER				24	415 W. VERNON AVENUE			
CASWELL CENTER				к	INSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 249	on crisis supervision we supervision around the has passed the inedial confirmed that direct of searches three times searches on a room searches of having surgery repair to the improper ingest. Interview on 6/29/23 we for the search and seizer the search and seizer for confirmed client with the search and seizer for confirmed client we search are start supervised and seizer for confirmed client with the search and searc	was subsequently placed which requires 2:1 e clock until it is verified he ble item. Additional interview care staff complete room daily and document these bearch and seizure form. lient #1 has a history in 2011 of his colon completed due tion of an inedible item. with staff A confirmed client vision in his living unit and ision which increases his makes allegations or direct may have swallowed an interview confirmed direct at #1 complete daily room ad personal belongings is documented on room rms. Additional interview ceives 2:1 supervision with staff B revealed client vision in his living unit and ision if he makes are staff suspect he may	w	249		EFICIENCY)		
	personal belongings t documented on room Additional interview co 2:1 supervision outsid Interview on 6/29/23 v specialist (BPS) conf	hree times daily that is search and seizure forms. onfirmed client #1 receives						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2023 APPROVED 0: 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G001	B. WING		_		C 29/2023	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE			
CASWELL CENTER				415 W. VERNON AVENUE INSTON, NC 28501				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 249 W 252	form. Further interview been some lapses in a investigated in May. A confirmed client #1 ha in in 6 months which i piece of a styrofoam f an intravenous vein s and 2 triple A batteries specialist provided clii for June 2023 which r 6/17/23 (third shift): n 6/18/23: (third shift) n 6/23/23: (third shift) n 6/28/23: (thir	bom search and seizure ws confirmed there had data that had been Additional interviews as ingested 4 inedible items included: a surgical mask, from a headpiece, a piece of etup kit at the local hospital s. The behavioral program ent #1's room search sheets revealed the following: o data o data o supervisor signature o data with the qualified intellectual al (QIDP) revealed failure to s on 6/17/23, 6/18/23, vas a failure to implement itten. ENTATION) mplishment of the criteria vidual program plan boumented in measurable	W 249					

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		MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED	
					С		
		34G001	B. WING		06/29/2023		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
CASWELL CENTER				2415 W. VERNON AVENUE			
CASWELL CENTER				KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
W 252	- 15	e 4	W 252	2			
	102. The finding is:						
	program plan (IPP) d #1 has Mild Intellectu Schizoaffective Disor several target behavi aggression, self-injuri of self harm, ingestion destruction, task relat non-compliance, verb allegations and inapp Review on 6/29/23 of 10/11/22 revealed the of: physical aggressio (SIB), threats of self h property destruction, non-compliance, verb	Review on 6/29/23 of client #1's individual program plan (IPP) dated 4/6/23 revealed client #1 has Mild Intellectual Disabilities, Schizoaffective Disorder, Bipolar Type and has several target behaviors which include: physical aggression, self-injurious behavior (SIB), threats of self harm, ingestion related SIB, property destruction, task related avoidance and non-compliance, verbal aggression, false allegations and inappropriate telephone use. Review on 6/29/23 of client #1's BSP dated 10/11/22 revealed the following target behaviors of: physical aggression, self-injurious behavior (SIB), threats of self harm, ingestion related SIB, property destruction, task related avoidance and non-compliance, verbal aggression, false allegations and inappropriate telephone use					
	clothing nd personal l closet, plexiglass over 1:1 supervision in his supervision outside th checks of his room an three times daily that search and seizure for the BSP revealed if s swallowed an inedible immediately and he is supervision which rec	belongings in a locked er his television and remote, living unit and 2:1 ne living unit, daily room nd personal belongings is documented on room orms. Additional review of taff suspect client may have e item, Nursing is notified					
	the inedible item. Interview on 6/29/23 client #1 receives 1:1	with Nurse A confirmed supervision in his living unit upervision, which increases					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2023 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED		
		34G001	B. WING		C 06/29/2023		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
			24	15 W. VERNON AVENUE			
CASWELL CENTER			к	INSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
W 252	his staffing ratio to 2: direct care staff susper an inedible item. Inter care staff complete ro daily and document th search and seizure for Interview on 6/29/23 w #1 receives 1:1 super also has crisis superv allegations or direct c have swallowed an in interview confirmed d #1 complete daily roo personal belongings t documented on room Interview on 6/29/23 #1 receives 1:1 super also has crisis superv allegations or direct c have swallowed an in interview confirmed d #1 complete daily roo personal belongings t documented on room Interview confirmed d #1 complete daily roo personal belongings t documented on direct c have swallowed an in interview confirmed d #1 complete daily roo personal belongings t documented on room Interview on 6/29/23 w specialist (BPS) confi checks are to be com documented on the roo form. Further interview been some lapses in investigated in May 22 confirmed client #1 ha in in 6 months which in piece of a styrofoam f an intravenous vein s	1 if he makes allegations or ect he may have swallowed view confirmed that direct oom searches three times hese searches on a room orm. with staff A confirmed client vision in his living unit and rision if he makes are staff suspect he may edible item. Further irect care assigned to client m checks of his room and hree times daily that is search and seizure forms. with staff B revealed client vision in his living unit and rision if he makes are staff suspect he may edible item. Further irect care assigned to client vision in his living unit and rision if he makes are staff suspect he may edible item. Further irect care assigned to client m checks of his room and three times daily that is search and seizure forms. with the behavioral program rmed client #1's room pleted three times daily and poom search and seizure ws confirmed there had	W 252				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2023 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G001	B. WING				C 06/29/2023		
NAME OF P	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STAT	TE, ZIP CODE			
CASWELI					415 W. VERNON AVENUE (INSTON, NC 28501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
W 252	specialist provided cli for June 2023 which r 6/17/23 (third shift): n 6/18/23: (third shift) n 6/23/23: (third shift) n 6/28/23: (third shift) n Interview on 6/29/23 y disabilities profession record data for room 6/18/23, 6/23/23 and	ent #1's room search sheets revealed the following: o data o data o supervisor signature o data with the qualified intellectual al (QIDP) revealed failure to	W	252					

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