STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G243	A. BUILDING _____ B. WING _____	C 04/10/2024

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W 000	INITIAL COMMENTS A complaint survey was completed on 4/10/24 for Intake #NC00215574. The intake was substantiated. Deficiencies were cited.	W 000		
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 reviews and interviews, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 2 audit clients (#2). The finding is: Review on 4/10/24 of event reports revealed client #2 had a torn area below the right elbow on 2/4/24. The client stated he fell behind the bed trying to reach something, but the fall was unwitnessed by staff. The injury was noticed as he was trying to get into the shower. The nurse checked the area and it was cleaned with band aid. A second event report was revealed client #2 had another unwitnessed fall on 3/11/24, resulting in a fractured rib. No facility investigation was initiated for either event. Review on 4/10/24 of the facility Incident Response Improvement System (IRIS) reports, revealed one report, dated 3/15/24, for an incident on 3/11/24. Client #2 "fell out of bed and when he went to a doctor's appointment on Thursday, it was determined he had a fractured rib on his left side." Review on 4/10/24 of client #2's nursing notes revealed on 3/11/24, he was taken to the hospital for evaluation of aspiration after choking on a	W 154		

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

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piece of meat and also evaluation after a fall in the home. He was discharged back to group home with no new order. On 3/12/24, an x-ray with his physician revealed an esophageal obstruction and received a muscle relaxant to help pass the obstruction. A CT chest x-ray was ordered. On 3/13/24, CT included focal pleural thickening in the lung base posteri, adjacent to a fracture of the ninth rib, possibly associated with trauma causing the fracture such as hematoma or some pleural thickening edema from the injury.

Review on 4/10/24 of physician notes, dated 3/12/24, revealed client #2 was still coughing and not acting like himself per staff. On 3/11/24, he was seen at the emergency room to have evaluation of fall and cough that now has a gurgling sound in chest. Staff was unsure of how he fell or what was hit. On 3/12/24, he would not eat as usual. Labs were completed and a chest x-ray was recommended with overnight spot checks for O2 levels.

Review on 4/10/24 of client #2's hospital radiology report, dated 3/13/24, revealed focal pleural thickening in the left lung base posteriorly but appears to be adjacent to a fracture of the ninth rib with offset by one bone width.

Review on 4/10/24 of client #2's BSP, dated 9/5/22, revealed target behaviors to include polydipsia, Pica, SIB, wandering off, severe disruptive behavior, aggression, and property destruction. Pica involves attempting to drink liquid soap. Polydipsia is an uncontrollable urge to drink water. Client #2 should never have access to soap items without staff being right beside him. He should never be left alone in the bathroom as he might drink toilet water and has

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broken several commode handles attempting to flush the commode. Staff should always accompany him to the toilet. He has one-to-one supervision at all times. At night when client #2 is asleep, the one-to-one staff should be stationed outside his bedroom door. He has a bed alarm with monitor. If noises are heard over the monitor that suggests he may be trying to get up, staff should immediatly visually monitor him.

Interview on 4/10/24 with Staff A revealed client #2 had been up and down all night trying to flush the toilet on 3/10/24. Normally on third shift, staff take turns "dealing with his behavior" and sit by his door to hear his alarm. On the morning of 3/11/24, Client #2 was awake and dressed for the day in his bedroom. No staff was at his bedroom door to observe him or monitor the alarm. Staff A was in the kitchen getting breakfast ready when she heard a loud sound. She ran to client #2's room and found him on the floor. She then assisted him up and told him to be careful.

Interview with LPN #1 revealed client #2 receives one-to-one supervision. Staff said he fell on 3/11/24, and the facility nurses told staff to monitor him and report the incident. Client #2 came in the day program and choked on food on the same day he had fallen at home. He was sent to the emergency room, and they cleared his throat. They sent him home, but he kept coughing. He was then seen by the primary physician, who sent him for an x-ray and discovered he had a broken rib. Details of the fall were not relayed to nursing.

Interview on 4/10/24 with the QIDP revealed she was unaware client #2 had been in behavior the previous night of having a broken rib. She stated

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W 154	Continued From page 3 she received the report from third shift staff and was not aware of what was written in behavior documentation. The QIDP did not offer further reasons as to why the unwitnessed injury was not investigated.	W 154		
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 reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the behavior support plan (BSP) for 1 of 2 audit clients (#2). The finding is: Review on 4/10/24 of client #2's BSP, dated 9/5/22, revealed target behaviors to include polydipsia, Pica, SIB, wandering off, severe disruptive behavior, aggression, and property destruction. Pica involves attempting to drink liquid soap. Polydipsia is an uncontrollable urge to drink water. Client #2 should never have access to soap items without staff being right beside him. He should never be left alone in the bathroom as he might drink toilet water and has broken several commode handles attempting to	W 249		

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flush the commode. Staff should always accompany him to the toilet. He has one-to-one supervision. At night, the one-to-one should be stationed outside his bedroom door. If noises are heard over the monitor that suggest he may be trying to get up, staff will immediately visually monitor him.

Review on 4/10/24 of client #2's behavior data revealed he kept going to the bathroom to flush the toilet and yelling "all shift" on 3/10/24 during third shift, recorded by Staff #1. Intervention was recorded as "Get him out the bathroom".

Review on 4/10/24 of event reports revealed client #2 had a torn area below the right elbow on 2/4/24. The client stated he fell behind the bed trying to reach something. The injury was noticed as he was trying to get into the shower and was unknown in origin. On 3/11/24, an event report revealed client #2 fell out of the bed on 3/11/24 and fractured his rib on his left side. The fall was unwitnessed.

Interview on 4/10/24 with Staff A revealed client #2 had been up and down all night trying to flush the toilet on 3/10/24. Third shift staff normally takes turns in dealing with his behavior. On morning of 3/11/24, client #2 was dressed and in his bedroom. No staff was at the door to observe him. Staff A was in the kitchen preparing breakfast when she heard a loud sound. She ran to client #2's room and found him on the floor. She then assisted him up and told him to be careful.

Interview on 4/10/24 with Staff B revealed client #2 receives one-to-one supervision, but he goes to his room sometimes. She was not working on

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the night of 3/10/24 or during the day on 3/11/24, but she stated that there are usually only two staff on duty on weekend nights for third shift. When two staff are utilized, one has to get breakfast ready, and the other staff has to watch all the clients.

Interview with Staff C on 4/10/24 revealed she was not working on the day that client #2 fell. Supervision for client #2 would be one-to-one at all times, unless in his bedroom. If he is in the bedroom, staff should sit outside of his door and supervise him. At night, he has an alarm on his bed so that staff can go in if he gets up.

Interview with Staff D on 4/10/24 revealed she works first shift in the home. She is aware that client #2 should have a one-to-one staff with him at all times or outside of his bedroom door.

Interview with Staff E on 4/10/24 revealed client #2 has one-to-one supervision and staff outside his bedroom door.

Interview with Staff F revealed she works on first shift in the home and is client #2's one-to-one. During the day, they sit at the table and do activities. If he goes to the bathroom, she goes with him. If he is in his room, he does not want staff in the room, so staff should sit outside of his bedroom door in case he needs something. He has an alarm on his bed to know if he gets up from the bed at night.

Interview on 4/10/24 with the home supervisor revealed on 3/11/24, staff were probably trying to get breakfast ready, but a staff should have been outside of client #2's door his supervision. The supervisor revealed a requisition for an extra third

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W 249	Continued From page 6 shift staff submitted to the human resources department and stated they are ensuring weekend third shift staff include staff coverage for one-to-one supervision. Interview on 4/10/24 with the QIDP revealed she was unaware client #2 had been in behavior during the night on 3/10/24. She received the report of his fall from third shift staff and was not aware of what was written in behavior documentation. The QIDP confirmed that client #2 should have one-to-one supervision as specified in his BSP with a staff stationed at his bedroom door.	W 249		