STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G009	A. BUILDING _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT CREEK	5709 US 70 EAST GOLDSBORO, NC 27534

(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 12/12/2023 for intake #NC00210607. The complaint was substantiated. Deficiencies were cited. It was determined by the team on site that an immediate jeopardy was present to the clients. The interdisciplinary team was able to develop a comprehensive plan to remove the jeopardy to the clients, which was accepted by the survey team before their exit from the facility.	W 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider or the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
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 prohibited neglect of a client (W149); and failed to 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	A written protocol for the use of a warming unit will be implemented. The facility management team will be in-serviced to investigate allegations of neglect thoroughly. Administrator will ensure all allegations are investigated thoroughly and reported to appropriate officials.	1.20.2024
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 1 of 1 deceased client (dc #1) was not subject to unintentional neglect. The finding is:	W 149		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kim Hughes TITLE Facility Administrator (X6) DATE 12/22/23

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.

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W 149	Continued From page 1 Review on 12/11/23 of the Incident Response Improvement System (IRIS) report, dated 9/26/23, revealed dc #1 died on 9/22/23. Further review of the IRIS report revealed on 9/21/23, dc #1 was sent to the hospital due to large, dark brown emesis that tested positive for blood; he was evaluated and returned to the facility at 3:30pm. Upon return to the facility, dc #1 was alert and active with monitoring throughout the evening and night noting no distress. On 9/22/23 at approximately 10:30am, the licensed practical nurse (LPN) was called to dc #1's bedside by direct support associate (DSA) staff. The LPN noted him to be actively seizing and administered Valtoco nasal spray per order without success. The LPN administered a second dose of Valtoco as ordered. Vital signs for dc #1 were abnormal with oxygen saturation at 84% on room air with oxygen applied, which increased sats to 100%, heart rate of 150-160s and rectal temperature of 108.6. The doctor was immediately notified, and dc #1 was sent to the hospital. While at the hospital, he received treatment from hospital staff. The facility received a call from dc #1's doctor stating his condition was grave. The doctor stated he had spoken to dc #1's mother and would be initiating comfort measures. On 9/22/23, dc #1 passed away in the hospital. Review on 12/11/23 of the facility's documents revealed no investigation regarding the incident on 9/22/23. Review on 12/11/23 of dc #1's Individual Program Plan (IPP), dated 2/22/23, revealed a diagnosis to	W 149	No individual at Walnut Creek currently has an order to use a warming unit. A written protocol for the use of a warming unit will be implemented. The facility management team will be in-serviced to investigate allegations of neglect thoroughly. Administrator will ensure all allegations are investigated thoroughly and reported to appropriate officials. All nursing staff to be trained on how to properly use a warming unit and the importance and protocol to follow all physician orders. All staff to be trained on the proper use of a Warming Unit to include the following: - Only licensed personnel to apply the warming unit to an individual - Application/Removal of the warming unit will be documented in Therap/Quickmar - Monitoring of temperature while warming unit is in place will be completed and documented every 15 minutes and/or according to manufacturer recommendations - Application of the warming unit to be applied only if meets written physician parameters.	1.20.2024

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W 149	Continued From page 2 include Seizure Disorder and Hypothermia. The IPP revealed dc #1 is non-ambulatory, has limited use of his arms and hands, and is dependent upon staff for movement and positioning. The IPP further revealed he has occasional episodes of hypothermia with temperature monitoring by nurses every shift. The IPP noted that if his temperature is less than 95 degrees, warm blankets should be placed on him. In addition, dc #1 should wear a toboggan, thermals, and layered clothing to keep his temperature greater than 95 degrees. Any variations of the protocol will be determined by the nursing staff. Review on 12/11/23 of physician's orders for dc #1, dated 8/1/23, revealed a diagnosis to include Trauma, Constipation, Hyponatremia, Hypothermia, Dysphagia, Quadriplegia, Gastroesophageal Reflux Disease, Intellectual Disability, Muscle Spasticity, Optic Atrophy, Allergic Rhinitis, Scoliosis, Delayed Gastric Emptying, Bilateral Nephrolithiasis, Seizure Disorder. Temperature checks should be checked each shift. If noted below 96 degrees, apply thermals, warm blankets, and hat due to his Hypothermia. Review on 12/12/23 of physician's orders for dc #1, dated 7/27/23, revealed a prescribed rectal temperature check every shift with the use of the Bair Hugger device for temperatures less than 90 degrees. Review on 12/11/23 of dc #1's rectal temperature monitoring data revealed the following: - 9/22/23 at 12:03am temperature of 96.1 - 9/22/23 at 5:32am temperature of 97.6 - 9/22/23 at 8:07am temperature of 98.4 - 9/22/23 at 10:30am temperature of 109	W 149	Informal monitoring to occur through daily observations by Administrative Staff, Nurse Team Leaders, DON, Supervisors, and QP's. Formal monitoring to occur at least monthly through completion of the Interaction assessment.	

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W 149	Continued From page 3 Further review of dc #1's record revealed no documentation for the use of the Bair Hugger, when it was applied or monitored. Interview on 12/12/23 with Staff E, revealed she worked 1st shift 9/22/23. She walked the hall at approximately 10:00am and heard dc #1 breathing heavy. She then went in to check him and found him limp and hot to touch. He was wearing full thermal pajamas, the Bair Hugger warming blanket, and a lot of blankets on him. In addition Staff E confirmed the Bair Hugger was turned on when she went into the room. She removed all of the blankets and called for the LPN. She remained in the room while the LPN checked his temperature. His temperature was 108 degrees Fahrenheit rectally. Staff immediately called EMS. Further interview on 12/12/23 with Staff E revealed she was unaware of who applied the Bair Hugger on dc #1. Usually the nurses were responsible for applying and monitoring the use of the Bair Hugger. Staff E had not been trained in this area. Interview on 12/12/23 with Staff C revealed she had worked 1st shift on 9/22/23 and briefly looked into dc #1's room after arriving to work. Staff C did not enter his room at this time. Later in the morning, Staff C was notified by the medical technician that there was a concern with dc #1's body feeling warm to touch. When Staff C arrived in his room, his covers had been removed, and he was wearing his thermals. Staff C determined dc #1 was having seizures, so she sent for his Valtoco and took his vitals. DC #1's vital signs were were taken and abnormal with a rectal temp	W 149		

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W 149	Continued From page 4 of 108.4. Staff C then determined dc #1 needed to go to the hospital, and the medical provider was notified. Further interview on 12/12/23 with Staff C revealed the Bair Hugger was in dc #1's room, but she did not see it on him when she arrived. Staff C revealed the Bair Hugger is used on him when his temperature is 95 or below rectally and usually monitored every three hours. The Bair Hugger should be removed when his temperature is above 97. Staff C revealed whoever finds dc #1's temperature low should apply the Bair Hugger, but the medical technicians are suppose to ask the nurse to apply it. Staff C stated the facility nurse provides training for Bair Hugger use including the application and monitoring. Interview on 12/11/23 with Staff A revealed dc #1 was always in good health until the time he passed away, but that there had been several times the Bair Hugger was used on him because his temperature dropped. His temperature was normal on 9/21/23, and he seemed to be acting like himself. On 9/22/23, Staff A arrived at work for 1st shift and walked by dc #1's room to briefly speak to him. He responded by looking up and making a sound verbally. Staff A saw the Bair Hugger at the end of his bed, but she could not see if it was applied to him because he was covered with his comforter. Later in the morning, Staff A saw people going to dc #1's room. Staff A stated somebody had told her the Bair Hugger was on him, and his temperature was 108. Staff A was asked by other staff if she had heard the machine. Staff A did not hear the Bair Hugger, but she believed it was being used on him with his thermal pajamas and bed comforter on 9/22/23. Normally, when his temperature drops, warmed	W 149		

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W 149	Continued From page 5 towels from the dryer are used before the nurses apply the Bair Hugger, and monitoring should be done by nurses when using the Bair Hugger. Interview on 12/11/23 with Staff B revealed dc #1's temperature had not risen to above 105 degrees prior to 9/22/23 as far as he knew. When his temperature dropped to 95 degrees or lower, staff applied warm blankets from the dryer. Staff would then monitor his temperature every 30 minutes or based on nurses judgement. Interview on 12/11/23 with Staff D revealed dc #1 was always cold. Staff D stated she usually took his temperature upon arriving at work and contacted the nurse when it was below 96 degrees. Normally, the nurse comes to treat dc #1 and she assists with what the nurse needs. If his temperature was below 96 degrees, the nurses apply a "heating blanket" on him. Staff D described the heating blanket as a thin, white blanket that hooks up to a machine, and blows hot air across his body. When shown pictures of a 3M Bair Hugger equipment, Staff D pointed to pictures of a warming unit and warming blanket to identify equipment used with dc #1. Staff D stated the machine did not have a temperature monitor on it, so she would have to go in and check his temperature rectally with a thermometer. When dc #1's temperature had risen, she told the nurses and they told her to not use it anymore once the temperature was ok. Staff D tried to check on him every 15 minutes, no later than 30 minutes but was unsure of how often to check him the the Bair Hugger was in use. She had never known his temperature to spike to high temperatures such as 106 and above because his temperature was usually low.	W 149		

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W 149	Continued From page 6 Review on 12/11/23 of the 3M Bair Hugger Warming Unit Operating Manual revealed the system should only be used by trained medical professionals per a medical order. Safe usage requires the use of three components: the warming unit, warming blanket, and temperature monitor. Precautions to reduce the risk of thermal injury include recommended continuous monitoring of core temperatures. If continuous monitoring is not possible, the manual revealed a minimum of 15 minute temperature checks for safety. However, infants, children and other vulnerable patient population should not be left unattended during warming therapy. Air temperature should be discontinued or adjusted once the therapeutic goal is reached, if elevated temperatures are recorded or there is an adverse response. Interview on 12/11/23 with the facility social worker revealed dc #1 had a diagnosis of Hypothermia and usually wore thermals all day. However, if his temperature dropped, staff would put a warming blanket on him. The facility social worker later stated she meant to say warmed blankets from the dryer. Interview on 12/11/23 with the administrator revealed dc #1 had an increase in seizures over the past few months. However, he had not normally had temperature rises due to seizures before and he had not been sick. The facility had not completed an investigation because they found no suspicious behavior, and felt it was all medical issues. The administrator stated the hospital was trying to find out why his temperature was high and it was a "mystery" to the hospital.	W 149		

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W 149	Continued From page 7 Interview on 12/11/23 with the Regional Director of Nursing (RDON) revealed staff tried to monitor clients vitals "like every 30 minutes". The RDON revealed if there is a crisis in temperature drops/rises, there is no facility protocol for increased monitoring times. Monitoring would be increased according to nurses' judgement. Further interview on 12/12/23 with RDON revealed the facility had a lead trainer who conducts training for nurses and staff. In addition, the RDON completes follow up training for nurses and staff also. Training on the Bair Hugger would have been completed by other nurses, but the RDON stated it is "not something we just go and train on because it isn't used much." Normally, clients are checked every 30 minutes, and if the temperature is not normal within an hour, we contact the doctor. Documentation for temperature checks should be documented in QuickMAR most of the time, but may also be in nurses notes. The RDON stated an investigation was not completed on dc #1's case. Review on 12/12/23 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. This includes failing to follow through with doctor orders, failing to provide adequate staff training for medical treatment, failing to report abuse/neglect, and failing to have adequate monitoring systems. 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	W 149		

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W 149	Continued From page 8 substantiated allegation of neglect whereby there was harm to the person or significant risk for harm. The facility was notified by the surveyors on 12/12/23 that immediate jeopardy existed in the facility based on review of the client records and staff interviews as there were found to be 3 other clients at the facility with Hypothermia issues. Interviews revealed dc #1 was placed on the Bair Hugger on 9/22/23. The facility failed to follow his physician orders pertaining to the Bair Hugger warming unit. Physician orders stipulated his temperature to be 90 degrees or below as the determining factor for applying the unit. The lowest recorded temperature on 9/22/23 was 96.1. In addition, the facility failed to provide adequate staff training for medical treatment. Interviews revealed nurses and staff were unsure of what dc #1's temperature should have been before applying the Bair Hugger, as well as what his temperature should have been to remove the device. Interviews revealed nurses and staff were not aware of safety precautions regarding monitoring of his temperature while the Bair Hugger was in use. The facility failed to provide adequate monitoring to him while the Bair Hugger was used. The manufacturer recommends continuous temperature monitoring for vulnerable patients, with a 15 minute minimum in cases when continuous monitoring is not possible. Temperature monitoring data revealed dc #1's temperature was not monitored continuously or every 15 minutes; data revealed his temperature monitoring on 9/22/23 to be in spans of 2 to 5	W 149		

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W 149	Continued From page 9 hours apart, all resulting in the neglect of dc #1. The facility responded with the following plan of protection actions. The adminstrator and RDON will ensure the plan of protection is implemented. -Facility management will investigate possible neglect thoroughly in relation to an individual being sent out to the emergency department, based on the outcome of he investigation, appropriate corrective action will be addressed. -Nursing staff will be trained on how to use a warming unit and the importance/protocol to follow all physician orders. No individual at Walnut Creek currently has a standing order to use the warming unit, and the warming unit is not currently available while relocated at Caswell. -All staff will be trained on the proper use of Bair Hugger/Warming Unit to include only licensed personnel to apply the warming unit. -All staff will be trained on temperature monitoring and removal of Bair Hugger per manufacturer safety recommendations. -All staff will be trained in proper documentation related to the application and removal of the Bair Hugger, as well as monitoring. After reviewing the plan of protection developed by the facility on 12/12/23, 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	W 154		

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W 154	Continued From page 10 affected 1 of 1 deceased client (dc #1). The finding is: Review on 12/11/23 of the Incident Response Improvement System (IRIS) report, dated 9/26/23, revealed dc #1 died on 9/22/23. Further review of the IRIS report revealed on 9/21/23, dc #1 was sent to the hospital due to large, dark brown emesis that tested positive for blood; he was evaluated and returned to the facility at 3:30pm. Upon return to the facility, dc #1 was alert and active with monitoring throughout the evening and night noting no distress. On 9/22/23 at approximately 10:30am, the licensed practical nurse (LPN) was called to dc #1's bedside by direct support associate (DSA) staff. The LPN noted him to be actively seizing and administered Valtoco nasal spray per order without success. The LPN administered a second dose of Valtoco as ordered. Vital signs for dc #1 were abnormal with oxygen saturation at 84% on room air with oxygen applied, which increased sats to 100%, heart rate of 150-160s and rectal temperature of 108.6. The doctor was immediately notified, and dc #1 was sent to the hospital. While at the hospital, he received treatment from hospital staff. The facility received a call from dc #1's doctor stating his condition was grave. The doctor stated he had spoken to dc #1's mother and would be initiating comfort measures. On 9/22/23, dc #1 passed away in the hospital. Review on 12/11/23 of the facility's documents revealed no investigation regarding the incident on 9/22/23.	W 154	No individual at Walnut Creek currently has an order to use a warming unit. A written protocol for the use of a warming unit will be implemented. The facility management team will be in-serviced to investigate allegations of neglect thoroughly. Administrator will ensure all allegations are investigated thoroughly and reported to appropriate officials. All nursing staff to be trained on how to properly use a warming unit and the importance and protocol to follow all physician orders. All staff to be trained on the proper use of a Warming Unit to include the following: - Only licensed personnel to apply the warming unit to an individual - Application/Removal of the warming unit will be documented in Therap/Quickmar - Monitoring of temperature while warming unit is in place will be completed and documented every 15 minutes and/or according to manufacturer recommendations - Application of the warming unit to be applied only if meets written physician parameters.	1.20.2024

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W 154	Continued From page 11 Review on 12/11/23 of dc #1's Individual Program Plan (IPP), dated 2/22/23, revealed a diagnosis to include Seizure Disorder and Hypothermia. Review on 12/11/23 of dc #1's Individual Program Plan (IPP), dated 2/22/23, revealed a diagnosis to include Seizure Disorder and Hypothermia. The IPP noted that if his temperature is less than 95 degrees, warm blankets should be placed on him. In addition, dc #1 should wear a toboggan, thermals, and layered clothing to keep his temperature greater than 95 degrees. Any variations of the protocol will be determined by the nursing staff. Review on 12/11/23 of physician's orders for dc #1, dated 8/1/23, revealed a diagnosis to include Hypothermia. Temperature checks should be checked each shift. If noted below 96 degrees, apply thermals, warm blankets, and hat due to his Hypothermia. Review on 12/11/23 of dc #1's rectal temperature monitoring data revealed the following: - 9/22/23 at 12:03am temperature of 96.1 - 9/22/23 at 5:32am temperature of 97.6 - 9/22/23 at 8:07am temperature of 98.4 - 9/22/23 at 10:30am temperature of 109 Further review of dc #1's record revealed no documentation for the use of the Bair Hugger, when it was applied or monitored. Interview on 12/12/23 with Staff E, revealed she worked 1st shift 9/22/23 and check on dc #1 at approximately 10:00am. She noticed he was breathing heavy, as well as hot and limp to touch. She noticed the Bair Hugger device was applied to dc #1 at the time of her check. She called the	W 154	Informal monitoring to occur through daily observations by Administrative Staff, Nurse Team Leaders, DON, Supervisors, and QP's. Formal monitoring to occur at least monthly through completion of the QA Assessments (Interaction assessment, ICF Medical and Non-Medical Chart Audits, Medication Pass Audit).	

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W 154	Continued From page 12 LPN to check his temperature, and his temperature was 108 degrees. They immediately called 911. Interview on 12/12/23 with Staff C revealed she worked 1st shift on 9/22/23 and was called to dc #1's room during the morning shift. She noticed his covers had been removed when she entered his room, and he was wearing his thermals. Staff C stated the Bair Hugger was in dc #1's room, but it was not attached to him when she arrived. Staff C determined he was having seizures, so she sent for his Valtoco and took his vitals. DC #1's vital signs were taken and abnormal with a rectal temp of 108.4. Staff C immediately called 911. Interview on 12/11/23 with Staff A revealed she worked 1st shift on 9/22/23 and saw the Bair Hugger at the end of dc #1's bed. She did not know if the Bair Hugger was attached to him because he was covered with his comforter. Later in the morning, Staff A saw people going to dc #1's room, and she was told the Bair Hugger was on him. Staff A believed he was wearing the Bair Hugger, thermals, and his comforter. Interview on 12/11/23 with the administrator revealed dc #1 had an increase in seizures over the past few months. However, he had not normally had temperature rises due to seizures before and he had not been sick. The facility had not completed an investigation because they found no suspicious behavior, and felt it was all medical issues. The administrator stated the hospital was trying to find out why his temperature was high and it was a "mystery" to the hospital. Interview on 12/11/23 with the Regional Director	W 154		

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W 154	Continued From page 13 of Nursing (RDON) revealed staff tried to monitor clients vitals "like every 30 minutes". The RDON revealed if there is a crisis in temperature drops/rises, there is no facility protocol for increased monitoring times. Monitoring would be increased according to nurses' judgement. Further interview on 12/12/23 with RDON revealed the facility Normally, clients are checked every 30 minutes, and if the temperature is not normal within an hour, we contact the doctor. Documentation for temperature checks should be documented in QuickMAR most of the time, but may also be in nurses notes. The RDON revealed death investigations are usually completed by the facility, but was not completed on dc #1's case. Review on 12/12/23 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. This includes failing to follow through with doctor orders, failing to provide adequate staff training for medical treatment, failing to report abuse/neglect, and failing to have adequate monitoring systems. 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 failed to adequately investigate and report the death of dc #1. The facility did not	W 154		

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W 154	Continued From page 14 report who applied the Bair Hugger device, determine if proper monitoring was completed, or complete a death investigation.	W 154		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: provide nursing oversight regarding the administration of medication administration and vital medical treatment (W331) and failed to provide adequate training for staff in the use of medical equipment, safety protocols, and documentation (W340). The cumulative effects of these systemic practices resulted in the facility's failure to provide statutorily mandated services in health care.	W 318	All nursing staff to be trained on how to properly use a warming unit and the importance and protocol to follow all physician orders. Informal monitoring to occur through daily observations by Nurse Team Leaders, DON and QP's. Formal monitoring to occur at least monthly through completion of the ICF Medical and Non-Medical Chart Audits.	1.20.2024
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on records review and interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 1 deceased client (dc #1) relative to ensuring physician orders were followed for the use of prescribed medical equipment. The finding is: Review on 12/11/23 of the Incident Response Improvement System (IRIS) report, dated 9/26/23, revealed dc #1 died on 9/22/23. Further	W 331	A written protocol for the use of a warming unit will be implemented. All nursing staff to be trained on the importance and protocol to follow all physician orders. Informal monitoring to occur through daily observations by Nurse Team Leaders, DON and QP's. Formal monitoring to occur at least monthly through completion of the ICF Medical and Non-Medical Chart Audits.	1.20.2024

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W 331	Continued From page 15 review of the IRIS report revealed on 9/21/23, dc #1 was sent to the hospital due to large, dark brown emesis that tested positive for blood; he was evaluated and returned to the facility at 3:30pm. Upon return to the facility, dc #1 was alert and active with monitoring throughout the evening and night noting no distress. On 9/22/23 at approximately 10:30am, the licensed practical nurse (LPN) was called to dc #1's bedside by direct support associate (DSA) staff. The LPN noted him to be actively seizing and administered Valtoco nasal spray per order without success. The LPN administered a second dose of Valtoco as ordered. Vital signs for dc #1 were abnormal with oxygen saturation at 84% on room air with oxygen applied, which increased sats to 100%, heart rate of 150-160s and rectal temperature of 108.6. The doctor was immediately notified, and dc #1 was sent to the hospital. While at the hospital, he received treatment from hospital staff. The facility received a call from dc #1's doctor stating his condition was grave. The doctor stated he had spoken to dc #1's mother and would be initiating comfort measures. On 9/22/23, dc #1 passed away in the hospital. Review on 12/11/23 of the facility's documents revealed no investigation regarding the incident on 9/22/23. Review on 12/11/23 of dc #1's Individual Program Plan (IPP), dated 2/22/23, revealed a diagnosis to include Seizure Disorder and Hypothermia. The IPP revealed dc #1 is non-ambulatory, has limited use of his arms and hands, and is dependent upon staff for movement and positioning. The IPP	W 331		

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W 331	Continued From page 16 further revealed he has occasional episodes of hypothermia with temperature monitoring by nurses every shift. The IPP noted that if his temperature is less than 95 degrees, warm blankets should be placed on him. In addition, dc #1 should wear a toboggan, thermals, and layered clothing to keep his temperature greater than 95 degrees. Any variations of the protocol will be determined by the nursing staff. Review on 12/11/23 of physician's orders for dc #1, dated 8/1/23, revealed a diagnosis to include Trauma, Constipation, Hyponatremia, Hypothermia, Dysphagia, Quadriplegia, Gastroesophageal Reflux Disease, Intellectual Disability, Muscle Spasticity, Optic Atrophy, Allergic Rhinitis, Scoliosis, Delayed Gastric Emptying, Bilateral Nephrolithiasis, Seizure Disorder. Temperature checks should be checked each shift. If noted below 96 degrees, apply thermals, warm blankets, and hat due to his Hypothermia. Review on 12/12/23 of physician's orders for dc #1, dated 7/27/23, revealed a prescribed rectal temperature check every shift with the use of the Bair Hugger device for temperatures less than 90 degrees. Review on 12/11/23 of dc #1's rectal temperature monitoring data revealed the following: - 9/22/23 at 12:03am temperature of 96.1 - 9/22/23 at 5:32am temperature of 97.6 - 9/22/23 at 8:07am temperature of 98.4 - 9/22/23 at 10:30am temperature of 109 Further review of dc #1's record revealed no documentation for the use of the Bair Hugger, when it was applied or monitored.	W 331		

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W 331	Continued From page 17 Interview on 12/12/23 with Staff E, revealed she worked 1st shift 9/22/23. She walked the hall at approximately 10:00am and heard dc #1 breathing heavy. She then went in to check him and found him limp and hot to touch. He was wearing full thermal pajamas, the Bair Hugger warming blanket, and a lot of blankets on him. In addition Staff E confirmed the Bair Hugger was turned on when she went into the room. She removed all of the blankets and called for the LPN. She remained in the room while the LPN checked his temperature. His temperature was 108 degrees Fahrenheit rectally. Staff immediately called EMS. Further interview on 12/12/23 with Staff E revealed she was unaware of who applied the Bair Hugger on dc #1. Usually the nurses were responsible for applying and monitoring the use of the Bair Hugger. Staff E had not been trained in this area. Interview on 12/12/23 with Staff C revealed she had worked 1st shift on 9/22/23 and briefly looked into dc #1's room after arriving to work. Staff C did not enter his room at this time. Later in the morning, Staff C was notified by the medical technician that there was a concern with dc #1's body feeling warm to touch. When Staff C arrived in his room, his covers had been removed, and he was wearing his thermals. Staff C determined dc #1 was having seizures, so she sent for his Valtoco and took his vitals. DC #1's vital signs were were taken and abnormal with a rectal temp of 108.4. Staff C then determined dc #1 needed to go to the hospital, and the medical provider was notified.	W 331		

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W 331	Continued From page 18 Further interview on 12/12/23 with Staff C revealed the Bair Hugger was in dc #1's room, but she did not see it on him when she arrived. Staff C revealed the Bair Hugger is used on him when his temperature is 95 or below rectally and usually monitored every three hours. The Bair Hugger should be removed when his temperature is above 97. Staff C revealed whoever finds dc #1's temperature low should apply the Bair Hugger, but the medical technicians are suppose to ask the nurse to apply it. Staff C stated the facility nurse provides training for Bair Hugger use including the application and monitoring. Interview on 12/11/23 with Staff A revealed dc #1 was always in good health until the time he passed away, but that there had been several times the Bair Hugger was used on him because his temperature dropped. His temperature was normal on 9/21/23, and he seemed to be acting like himself. On 9/22/23, Staff A arrived at work for 1st shift and walked by dc #1's room to briefly speak to him. He responded by looking up and making a sound verbally. Staff A saw the Bair Hugger at the end of his bed, but she could not see if it was applied to him because he was covered with his comforter. Later in the morning, Staff A saw people going to dc #1's room. Staff A stated somebody had told her the Bair Hugger was on him, and his temperature was 108. Staff A was asked by other staff if she had heard the machine. Staff A did not hear the Bair Hugger, but she believed it was being used on him with his thermal pajamas and bed comforter on 9/22/23. Normally, when his temperature drops, warmed towels from the dryer are used before the nurses apply the Bair Hugger, and monitoring should be done by nurses when using the Bair Hugger.	W 331		

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W 331	Continued From page 19 The facility failed to provide nursing services according to client needs as interviews revealed dc #1 was placed on the Bair Hugger device on 9/22/23 with the facility failing to follow dc #1's physicians' order. Physician orders stipulated dc #1's temperature be 90 degrees or below as the determining factor for applying the device. His lowest recorded temperature on 9/22/23 was 96.1 degrees. The facility also failed to ensure the client was appropriately monitored while the Bair Hugger was applied to ensure required temperature checks were completed.	W 331		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on record reviews and interviews, nursing services failed to provide adequate training for staff in the use of medical equipment, safety protocols, monitoring and documentation for 1 of 1 deceased client (dc #1). The finding is: Review on 12/11/23 of the Incident Response Improvement System (IRIS) report, dated 9/26/23, revealed dc #1 died on 9/22/23. Further review of the IRIS report revealed on 9/21/23, dc #1 was sent to the hospital due to large, dark brown emesis that tested positive for blood; he was evaluated and returned to the facility at 3:30pm. Upon return to the facility, dc #1 was alert and active with monitoring throughout the evening and night noting no distress.	W 340		

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W 340	Continued From page 20 On 9/22/23 at approximately 10:30am, the licensed practical nurse (LPN) was called to dc #1's bedside by direct support associate (DSA) staff. The LPN noted him to be actively seizing and administered Valtoco nasal spray per order without success. The LPN administered a second dose of Valtoco as ordered. Vital signs for dc #1 were abnormal with oxygen saturation at 84% on room air with oxygen applied, which increased sats to 100%, heart rate of 150-160s and rectal temperature of 108.6. The doctor was immediately notified, and dc #1 was sent to the hospital. While at the hospital, he received treatment from hospital staff. The facility received a call from dc #1's doctor stating his condition was grave. The doctor stated he had spoken to dc #1's mother and would be initiating comfort measures. On 9/22/23, dc #1 passed away in the hospital. Review on 12/11/23 of the facility's documents revealed no investigation regarding the incident on 9/22/23. Review on 12/11/23 of dc #1's Individual Program Plan (IPP), dated 2/22/23, revealed a diagnosis to include Seizure Disorder and Hypothermia. The IPP revealed dc #1 is non-ambulatory, has limited use of his arms and hands, and is dependent upon staff for movement and positioning. The IPP further revealed he has occasional episodes of hypothermia with temperature monitoring by nurses every shift. The IPP noted that if his temperature is less than 95 degrees, warm blankets should be placed on him. In addition, dc #1 should wear a toboggan, thermals, and layered clothing to keep his temperature greater	W 340	A written protocol for the use of a warming unit will be implemented. All nursing staff to be trained on how to properly use a warming unit and the importance and protocol to follow all physician orders. All staff to be trained on the proper use of a Warming Unit to include the following: - Only licensed personnel to apply the warming unit to an individual - Application/Removal of the warming unit will be documented in Therap/Quickmar - Monitoring of temperature while warming unit is in place will be completed and documented every 15 minutes and/or according to manufacturer recommendations - Application of the warming unit to be applied only if meets written physician parameters. Informal monitoring to occur through daily observations by Administrative Staff, Nurse Team Leaders, DON, Supervisors, and QP's. Formal monitoring to occur at least monthly through completion of the QA Assessments (Interaction assessment, ICF Medical and Non-Medical Chart Audits, Medication Pass Audit).	1.20.2024

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W 340	Continued From page 21 than 95 degrees. Any variations of the protocol will be determined by the nursing staff. Review on 12/11/23 of physician's orders for dc #1, dated 8/1/23, revealed a diagnosis to include Trauma, Constipation, Hyponatremia, Hypothermia, Dysphagia, Quadriplegia, Gastroesophageal Reflux Disease, Intellectual Disability, Muscle Spasticity, Optic Atrophy, Allergic Rhinitis, Scoliosis, Delayed Gastric Emptying, Bilateral Nephrolithiasis, Seizure Disorder. Temperature checks should be checked each shift. If noted below 96 degrees, apply thermals, warm blankets, and hat due to his Hypothermia. Review on 12/12/23 of physician's orders for dc #1, dated 7/27/23, revealed a prescribed rectal temperature check every shift with the use of the Bair Hugger device for temperatures less than 90 degrees. Review on 12/11/23 of dc #1's rectal temperature monitoring data revealed the following: - 9/22/23 at 12:03am temperature of 96.1 - 9/22/23 at 5:32am temperature of 97.6 - 9/22/23 at 8:07am temperature of 98.4 - 9/22/23 at 10:30am temperature of 109 Further review of dc #1's record revealed no documentation for the use of the Bair Hugger, when it was applied or monitored. Interview on 12/12/23 with Staff E, revealed she worked 1st shift 9/22/23. She walked the hall at approximately 10:00am and heard dc #1 breathing heavy. She then went in to check him and found him limp and hot to touch. He was wearing full thermal pajamas, the Bair Hugger	W 340		

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W 340	Continued From page 22 warming blanket, and a lot of blankets on him. In addition Staff E confirmed the Bair Hugger was turned on when she went into the room. She removed all of the blankets and called for the LPN. She remained in the room while the LPN checked his temperature. His temperature was 108 degrees Fahrenheit rectally. Staff immediately called EMS. Further interview on 12/12/23 with Staff E revealed she was unaware of who applied the Bair Hugger on dc #1. Usually the nurses were responsible for applying and monitoring the use of the Bair Hugger. Staff E had not been trained in this area. Interview on 12/12/23 with Staff C revealed she had worked 1st shift on 9/22/23 and briefly looked into dc #1's room after arriving to work. Staff C did not enter his room at this time. Later in the morning, Staff C was notified by the medical technician that there was a concern with dc #1's body feeling warm to touch. When Staff C arrived in his room, his covers had been removed, and he was wearing his thermals. Staff C determined dc #1 was having seizures, so she sent for his Valtoco and took his vitals. DC #1's vital signs were were taken and abnormal with a rectal temp of 108.4. Staff C then determined dc #1 needed to go to the hospital, and the medical provider was notified. Further interview on 12/12/23 with Staff C revealed the Bair Hugger was in dc #1's room, but she did not see it on him when she arrived. Staff C revealed the Bair Hugger is used on him when his temperature is 95 or below rectally and usually monitored every three hours. The Bair Hugger should be removed when his temperature	W 340		

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W 340	Continued From page 23 is above 97. Staff C revealed whoever finds dc #1's temperature low should apply the Bair Hugger, but the medical technicians are suppose to ask the nurse to apply it. Staff C stated the facility nurse provides training for Bair Hugger use including the application and monitoring. Interview on 12/11/23 with Staff A revealed dc #1 was always in good health until the time he passed away, but that there had been several times the Bair Hugger was used on him because his temperature dropped. His temperature was normal on 9/21/23, and he seemed to be acting like himself. On 9/22/23, Staff A arrived at work for 1st shift and walked by dc #1's room to briefly speak to him. He responded by looking up and making a sound verbally. Staff A saw the Bair Hugger at the end of his bed, but she could not see if it was applied to him because he was covered with his comforter. Later in the morning, Staff A saw people going to dc #1's room. Staff A stated somebody had told her the Bair Hugger was on him, and his temperature was 108. Staff A was asked by other staff if she had heard the machine. Staff A did not hear the Bair Hugger, but she believed it was being used on him with his thermal pajamas and bed comforter on 9/22/23. Normally, when his temperature drops, warmed towels from the dryer are used before the nurses apply the Bair Hugger, and monitoring should be done by nurses when using the Bair Hugger. Interview on 12/11/23 with Staff B revealed dc #1's temperature had not risen to above 105 degrees prior to 9/22/23 as far as he knew. When his temperature dropped to 95 degrees or lower, staff applied warm blankets from the dryer. Staff would then monitor his temperature every 30 minutes or based on nurses judgement.	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G009	A. BUILDING _____ B. WING _____	C 12/12/2023

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W 340	Continued From page 24 Interview on 12/11/23 with Staff D revealed dc #1 was always cold. Staff D stated she usually took his temperature upon arriving at work and contacted the nurse when it was below 96 degrees. Normally, the nurse comes to treat dc #1 and she assists with what the nurse needs. If his temperature was below 96 degrees, the nurses apply a "heating blanket" on him. Staff D described the heating blanket as a thin, white blanket that hooks up to a machine, and blows hot air across his body. When shown pictures of a 3M Bair Hugger equipment, Staff D pointed to pictures of a warming unit and warming blanket to identify equipment used with dc #1. Staff D stated the machine did not have a temperature monitor on it, so she would have to go in and check his temperature rectally with a thermometer. When dc #1's temperature had risen, she told the nurses and they told her to not use it anymore once the temperature was ok. Staff D tried to check on him every 15 minutes, no later than 30 minutes but was unsure of how often to check him the the Bair Hugger was in use. She had never known his temperature to spike to high temperatures such as 106 and above because his temperature was usually low. Review on 12/11/23 of the 3M Bair Hugger Warming Unit Operating Manual revealed the system should only be used by trained medical professionals per a medical order. Safe usage requires the use of three components: the warming unit, warming blanket, and temperature monitor. Precautions to reduce the risk of thermal injury include recommended continuous monitoring of core temperatures. If continuous monitoring is not possible, the manual revealed a minimum of 15 minute temperature checks for	W 340		

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W 340	Continued From page 25 safety. However, infants, children and other vulnerable patient population should not be left unattended during warming therapy. Air temperature should be discontinued or adjusted once the therapeutic goal is reached, if elevated temperatures are recorded or there is an adverse response. Interview on 12/11/23 with the facility social worker revealed dc #1 had a diagnosis of Hypothermia and usually wore thermals all day. However, if his temperature dropped, staff would put a warming blanket on him. The facility social worker later stated she meant to say warmed blankets from the dryer. Interview on 12/11/23 with the administrator revealed dc #1 had an increase in seizures over the past few months. However, he had not normally had temperature rises due to seizures before and he had not been sick. The facility had not completed an investigation because they found no suspicious behavior, and felt it was all medical issues. The administrator stated the hospital was trying to find out why his temperature was high and it was a "mystery" to the hospital. Interview on 12/11/23 with the Regional Director of Nursing (RDON) revealed staff tried to monitor clients vitals "like every 30 minutes". The RDON revealed if there is a crisis in temperature drops/rises, there is no facility protocol for increased monitoring times. Monitoring would be increased according to nurses' judgement. Further interview on 12/12/23 with RDON revealed the facility had a lead trainer who conducts training for nurses and staff. In addition,	W 340		

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W 340	Continued From page 26 the RDON completes follow up training for nurses and staff also. Training on the Bair Hugger would have been completed by other nurses, but the RDON stated it is "not something we just go and train on because it isn't used much." Normally, clients are checked every 30 minutes, and if the temperature is not normal within an hour, we contact the doctor. Documentation for temperature checks should be documented in QuickMAR most of the time, but may also be in nurses notes. The RDON stated an investigation was not completed on dc #1's case. Interviews revealed dc #1 was placed on the Bair Hugger on 9/22/23. Nurses and staff were not aware of safety precautions regarding monitoring of dc #1's temperature while the Bair Hugger was in use, resulting in the facility failing to provide adequate monitoring. The manufacturer recommends continuous temperature monitoring for vulnerable patients, with a 15 minute minimum in cases when continuous monitoring is not possible. Temperature monitoring data revealed dc #1's temperature was not monitored continuously or every 15 minutes; data revealed temperature checks performed in spans of 2 to 5 hours.	W 340		