STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G068	A. BUILDING _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOME	**1793 RIVERVIEW ROAD LINCOLNTON, NC 28092**

(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 7/9/24 for intake #NC00218278 and #NC00218281. The allegation was substantiated and deficiencies were cited.	W 000		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on observations, interviews, and documentation review, the facility failed to show evidence of appropriate corrective action for an incident of neglect for 6 of 6 clients (#1, #2, #3, #4, #5, #6). The finding is: Review of facility documentation on 7/9/24 revealed an internal investigation summary dated 6/11/24 relative to a third shift staff member coming to the facility for her shift around 10:00PM on 6/10/24 to find the clients unattended for at least 30 minutes. Continued review of the internal investigation summary indicated that on 6/10/24 at approximately 9:20PM, staff member A arrived at the facility and could not find a staff member present. The investigation summary also indicated that client #1 was still awake and opened the door for the staff. Continued review of the internal investigation revealed that staff member D later came into the kitchen and when questioned about her whereabouts she was mumbling, yawning, and stretching. Review of the internal investigation also revealed that staff A left the supplies with staff D and left the facility around 9:30PM. Further review of the investigative summary indicated that around 10:05PM a third shift staff member came to the	W 157		

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

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 157	Continued From page 1 facility at the start of her shift and did not find staff D present. It was also discovered that all six clients had been left unattended and unsupervised. Subsequent review of facility documentation revealed that staff D was questioned and placed on suspension until the conclusion of the internal investigation. The staff member (D) was later terminated on 6/12/24 and corrective actions were in place to ensure that an incident such as this one would not occur moving forward. The following corrective actions were recommended: termination of staff, in-service training on abuse, neglect, exploitation as well as client abandonment, increased clinical monitoring, and interaction/mealtime assessments at least three times weekly for 30 days. Review of facility documentation did not reveal evidence of interaction/engagement assessments, increased clinical monitoring, mealtime assessments, and in-service training with all facility staff after the incident (6/10/24). Therefore, corrective actions were not provided or completed as indicated in the internal investigative summary. Interview with the qualified intellectual disabilities professional (QIDP) on 7/9/24 indicated that staff D was terminated on 6/12/24. Continued interview with the QIDP verified she did not complete the remainder of the corrective actions as the staff in question was terminated and she felt that the clients were safe and well cared for by the seasoned staff that remain. Subsequent interview with the QIDP verified the facility did not complete the contents of the corrective action plan and they are currently out of compliance.	W 157		