

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2026
NAME OF PROVIDER OR SUPPLIER CASWELL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 W. VERNON AVENUE KINSTON, NC 28501		
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W 000	INITIAL COMMENTS A complaint survey was completed on 2/25/26 for intake #NC00236149. The complaint was substantiated.	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: The facility failed to: ensure that clients are not subjected to physical, verbal or psychological abuse or punishment and/or neglect (W127); and ensure allegations of abuse and neglect were thoroughly investigated (W154).	W 122			
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations, review of video surveillance footage and interviews, the facility failed to ensure 3 of 3 audit clients (#1, #2 and	W 127			

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 127	<p>Continued From page 1</p> <p>#3) residing in the home were not subject to abuse or neglect. The findings are:</p> <p>A. Review on 2/25/26 of the facility investigation dated 1/15/26 revealed that on 1/14/26 at 8:20pm, client #3 called advocacy services to report that client #1 hit him and a physical altercation ensued, and staff did not intervene to stop the altercation. Further review of the investigation revealed interviews with Staff B, C, F, G, H and I.</p> <p>Review on 2/25/26 of staff interviews completed during the investigation revealed the following:</p> <ul style="list-style-type: none"> - Staff B stated he has been trained to immediately intervene and stop clients when they are fighting. Staff B stated he has never been told to let them fight it out. Staff B confirmed that during the incident on 1/14/26, he and another staff were laughing and hugging before they assisted to intervene. - Staff C stated that he has been told that when two clients are fighting, he is supposed to let them fight it out. Staff C also revealed that during the incident on 1/14/26, he stood back and watched the clients fight and laughed, waiting for other staff to intervene. Staff C confirmed he did not intervene during the altercation. - Staff F stated she has been told not to separate clients if they are fighting. Staff also stated that during the incident on 1/14/26, she told client #1 and client #3 they had "five seconds to stop fighting" before staff would intervene. - Staff G stated she had been trained to let the clients fight it out and not to intervene, to prevent staff from being injured. Staff G revealed she saw other staff present during the altercation, so she left the home. - Staff H stated she has been advised by 	W 127			

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W 127	<p>Continued From page 2</p> <p>management in the home not to break up a fight between clients, so staff do not get hurt. Staff H confirmed that during the altercation on 1/14/26, she stood by and watched but did not intervene initially as she was waiting for male staff to intervene.</p> <p>- Staff I stated he was told to let clients sort it out themselves when they are fighting, to prevent staff injury. Staff I also revealed that during the incident on 1/14/26, he stepped into the laundry room when client #1 and client #3 were fighting. Staff I confirmed he did not intervene during the altercation but waited for other staff to intervene.</p> <p>Review on 2/25/26 of video surveillance footage dated 1/14/26 at approximately 7:35:26pm, client #3 was seen walking by the laundry room in his home. Client #1 was observed to reach out of the doorway of the laundry and punch client #3 in the face. Client #3 went into the laundry room and client #3 and client #1 began physically fighting. During the altercation, Staff B, C, F, G, H and I were observed standing in the laundry room, the doorway of the laundry room and the adjacent hallway. Further review of the video surveillance footage revealed Staff B, C, F, G, H and I to laugh, hug and give each other high-fives. Continued review of the video surveillance footage revealed staff did not intervene to de-escalate the altercation until 7:36:11pm.</p> <p>Interview on 2/25/26 with facility management revealed following the incident on 1/14/26, staff involved would be re-trained on facility policies for restarints and code of conduct, and each staff recieved a verbal coaching for their part in the incident.</p> <p>B. Review on 2/25/26 of video surveillance in the</p>	W 127			

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W 127	<p>Continued From page 3</p> <p>home on 2/20/26 at approximately 3:38pm, staff B is noted in the dayroom with client #2. Client #2 was observed to be attempting to walk around staff B and staff B continues to bump chest to chest with client #2 to prevent him from going down the hallway. Staff B takes his glasses off, bumps client #2 again and client #2 pushes staff B. Staff B was then observed to grab client #2 and shove him down onto the couch and got on top of him holding him down. Staff E was seen coming into the dayroom and motioning for the two to separate. Staff E is then seen knocking on a bedroom door and staff D comes out. Staff D takes client #2 out of camera view. Staff B was observed standing in the hallway pointing and motioning into client #1's bedroom. Staff B was then observed entering client #1's bedroom wearing a durag and a hoodie and then observed coming back out of the bedroom not wearing the durag or the hoodie and looking at his right inner arm. The video surveillance review also revealed the healthcare supervisor (HCS) I, nursing and medical going into the bedroom of client #1 to assess him.</p> <p>Review on 2/25/26 of an event report dated 2/20/26 revealed that client #1 had an injury due to aggression, resulting in "tooth luxation" (loose teeth due to trauma). Further review of the event report completed by Staff B was due to client #1 headbutting Staff B, resulting in Staff B placing client #1 in a CPI hold, at which time Staff B was "bitten" on his arm by client #1. Further review of the incident report's "management review" section completed by the healthcare supervisor (HCS) I revealed as part of the process, she interviewed client #1 and Staff B about the incident. Continued review of the event reports revealed no event report was completed for client</p>	W 127			

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W 127	<p>Continued From page 4 #2, nor was he assessed by medical staff.</p> <p>Interview on 2/25/26 with Staff E revealed that on 2/20/26, he was in the front living room and heard a commotion. Staff E stated at first, he thought client #2 and Staff B were "horseplaying," but soon realized the situation was much more serious. Staff E stated he separated client #2 and Staff B, then went to client #1's bedroom and told the developmental technician (DT) II that "something serious was going on and he needed to come handle it." Staff E confirmed that what he witnessed happening between client #2 and Staff B was "not normal" and was not a method of intervention that staff have been trained on. Staff E confirmed he did not call advocacy services to report the incident.</p> <p>Interview on 2/25/26 with Staff D revealed that on 2/25/26, he was in the bedroom with client #1 playing video games. Staff D revealed that Staff E came to the bedroom door to ask him to come out and "handle" a situation. Staff D stated he intervened to de-escalate client #2 and walked client #2 to the front living room. Staff D stated that a few moments later, client #1 tried to elope from the home. Staff D stated he assisted with getting client #1 back into the home, and noted client #1 was bleeding from his mouth. Staff D stated he was not sure "what happened in the bedroom between [client #1] and [Staff B]."</p> <p>Staff D also revealed that Staff B is a "man on man" type of staff. When asked what that meant, Staff D stated that Staff B operates under the rule that what he says goes, and if the clients in the home do not listen to him, he "handles" it in his own way. Staff D confirmed he called advocacy services to report client #1's attempted elopement</p>	W 127			

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W 127	<p>Continued From page 5 but did not call advocacy services regarding any other issue that day.</p> <p>Interview on 2/25/26 with the HCS I revealed she was the divisional contact on 2/20/26, meaning she was the responsible supervisor for the four homes in the division. The HCSI stated she was notified that client #1 had attempted to elope. When she went into the home, client #1 was bleeding from his mouth and was in his bedroom with the medical provider and the nurse. The HCSI stated she stood outside of the door of client #1's bedroom. The HCSI stated she did not interview client #1 following the incident, but did interview Staff B. The HCSI stated Staff B told her he was walking down the hallway when client #1 jumped out of his bedroom and attacked him, leading to client #1 and Staff B "wrestling." The HCSI confirmed she did not ask Staff B to clarify what he meant when he said he and client #1 were wrestling, and once again confirmed she did not interview client #1 following the incident. The HCSI also confirmed she did not ask Staff B about the discrepancies in his written statement and what he told her when she interviewed him, nor did she did call advocacy services to make any type of report.</p> <p>Advocacy was notified 2/24/26 by client #1 when he called to report the abuse by Staff B.</p> <p>Review on 2/25/26 of facility policy 2.2.9, "Abuse, Neglect, Exploitation and Violation of Rights of Residents" revealed the following: - Physical abuse is defined as the infliction of physical discomfort, pain or injury through the use of physical force other than accidental means resulting in, or creating, a significant potential for injury.</p>	W 127			

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W 127	<p>Continued From page 6</p> <p>- Emotional abuse is defined as abusive verbal or nonverbal interactions with, or in the presence of, residents that may result in distress, fear or a negative reaction.</p> <p>- Neglect is defined as the failure to provide care and services necessary to maintain the mental and physical health of the resident which results in, or creates, a significant potential for harm, pain, injury or distress; including failure to immediately notify designated supervisory staff and advocacy upon witnessing, hearing about or suspecting all alleged rights violations (including abuse, neglect and exploitation).</p> <p>Further review of facility policy 2.2.9 revealed that staff will immediately intervene upon witnessing, hearing about or suspecting abuse, neglect, exploitation or any other rights violations. Immediately after intervening, staff will report the incident to the manager on duty and report the incident directly to advocacy services.</p> <p>Review of facility policy 1.1.5, "Code of Conduct for Staff Interactions with Residents," revealed staff are to provide the residents with services and supports to foster independence and self-determination, afford residents with opportunities to make choices and decisions about their lives, and treat residents with respect, honesty, dignity, and recognition of their individuality.</p> <p>Review on 2/25/26 of facility policy 3.1.26, "Use of Manual and Mechanical Restraints in Severe Behavior Incidents," revealed staff must call advocacy services within one hour of restraint use. Further review of the policy revealed advocacy services should investigate unusual patterns of use.</p>	W 127			

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W 127	Continued From page 7 Interview on 2/25/26 with facility management revealed they were not aware of this incident until 2/24/26, when client #3 called advocacy to report the abuse by Staff B. Given that the facility failed to have an effective system in place to protect clients from abuse and neglect, an Immediate Jeopardy was called. The facility implemented a plan of protection, including 24 hour management oversight in the home, and retraining all staff at the facility globally. The plan of protection was reviewed and accepted by the survey team, reducing the Immediate Jeopardy to a Condition of Participation in Client Rights.	W 127			
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 potential abuse and investigate injuries following an alleged restraint for 1 of 3 audit clients (#1). The finding is: Review on 2/25/26 of the facility's event reports revealed a report completed by staff B on 2/20/26 at 3:38pm. The report revealed that client #1 headbutted him. Staff B then put client #1 in a hold and was bitten by the client. The report was reviewed and signed by the Health Care Supervisor (HCSI). The HCSI documented that staff B had been temporarily moved to another unit and also documented that she had interviewed the client at the time of the incident. Initial statements were written by staff present	W 154			

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W 154	<p>Continued From page 8</p> <p>and staff B documented that while dealing with a behavior for client #2, client #1 came out of his room cursing and telling staff what to do, then headbutted him, bit him and eloped to another unit. The event report revealed that the client sustained tooth luxation and was seen by medical. Client #1's diet was changed due to loose teeth, antibiotic was initiated, pain medication was ordered and dental referral completed.</p> <p>It should be noted that review on 2/25/26 of the employee incident report form completed by staff B and signed by the HCS1 on 2/20/26 revealed the incident occurred in the bedroom of client #1 and staff B documented he was walking down the hallway.</p> <p>Review on 2/25/26 of video surveillance in the home on 2/20/26 at approximately 3:38pm, staff B is noted in the dayroom with client #2. Client #2 was observed to be attempting to walk around staff B and staff B continues to bump chest to chest with client #2 to prevent him from going down the hallway. Staff B takes his glasses off, bumps client #2 again and client #2 pushes staff B. Staff B was then observed to grab client #2 and shove him down onto the couch and got on top of him holding him down. Staff E was seen coming into the dayroom and motioning for the two to separate. Staff E is then seen knocking on a bedroom door and staff D comes out. Staff D takes client #2 out of camera view. Staff B was observed standing in the hallway pointing and motioning into client #1's bedroom. Staff B was then observed entering client #1's bedroom wearing a durag and a hoodie and then observed coming back out of the bedroom not wearing a durag or the</p>	W 154			

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W 154	<p>Continued From page 9</p> <p>hoodie and looking at his right inner arm. The video surveillance review also revealed the HCS1, nursing and medical going into the bedroom of client #1 to assess him.</p> <p>Interview on 2/25/26 with advocacy revealed that they had not been made aware of the incident that occurred on 2/20/26 until client #1 contacted the department at approximately 3:40pm on 2/24/26. The advocacy department then initiated a formal inquiry and after watching video surveillance opened an investigation on 2/25/26. Advocacy revealed that initially after receiving the call from client #1, staff B was moved to another unit. However, once management was notified staff B was suspended pending investigation.</p> <p>Interview on 2/25/26 with the Director of Standards Management (DSM) revealed that an investigation would only be initiated following a restraint if there was a discrepancy in events. The DSM revealed that when injuries occur the supervisor who completes the report should observe the client and ask questions about the event.</p> <p>Further interview on 2/25/26 with the DSM, when asked if there had been any other known instances with staff B, revealed that staff B had been moved from Parrot 102 to Parrot 104 on 7/17/2025 after a client in Parrot 102 voiced that he felt uncomfortable being around staff B.</p> <p>During an interview on 2/25/26 with the HCSI, the supervisor that completed the event report, revealed she received a call client #1 attempted to elope. HCSI stated that when she arrived to the unit, client #1 was in his bedroom with the medical staff and that she stood at the door but</p>	W 154			

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W 154	<p>Continued From page 10</p> <p>did not speak to client #1 because his bedroom was torn up and he was upset. The HCSI revealed that when she questioned staff B about what occurred, he told her that he was walking down the hall and client #1 came out of his bedroom and started hitting him. The HCSI stated that she was unaware that the event report she signed said the incident occurred in the bedroom. The HCSI revealed she assumed client #1 accidentally injured himself while attacking staff. She also revealed she did not interview other staff because staff B told her no other staff were around to witness the incident. She confirmed she did not make any notifications to management or advocacy following the incident. The HCSI revealed staff B was moved to another home in the division for the remainder of his shift at the request of the division director.</p> <p>Interview on 2/25/26 with the nurse revealed she was called and told that an event report had been completed, and she needed to assess client #1. The nurse stated that when she arrived the client was bleeding from his mouth and had a loose tooth. The nurse revealed that she asked the client what caused his injury and he stated he had headbutted a staff. The nurse revealed that she was unaware that staff B had documented that client #1 was placed in a hold in his written statement and only knew because she overheard staff B telling someone else later. The nurse then completed a t-log entry at 5:21pm documenting that she did not witness and was not made aware of the hold.</p> <p>Interview on 2/25/26 with the division director revealed she was not aware of any incident on 2/20/26 involving client #2 and was only made aware of client #1 biting staff and eloping.</p>	W 154			

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W 154	Continued From page 11 Interview on 2/25/26 with the Therapeutic Response Team Lead (TRTL) revealed that he was called to the unit on 2/20/26 at approximately 4pm following an altercation between staff and client. He revealed when he arrived client #1 told him that staff B hit him in the mouth. The TRTL stated he took client #1 to the bathroom and helped him clean his face up and made sure the client was ok before he left. The TRTL revealed that he never notified advocacy or management of the accusation made by client #1 that he had been hit by staff B. Interviews on 2/25/26 with the staff involved and facility management revealed advocacy services should have been notified per facility policy 2.2.9. Management also confirmed that due to the discrepancies in the event report completed by staff B, an investigation should have been initiated immediately. The facility's failure to immediately notify advocacy services about potential abuse, neglect and deprivation prevented an immediate investigation to keep the clients' safe.	W 154			