STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

(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
F 160 SS=B	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident trust fund account statements and staff interviews, the facility failed to forward the entire balance of expired residents' personal fund accounts to the Clerk of Court or estate within 30 days of death for 3 of 3 reviewed expired residents (Residents #20, #50 and #144). The findings included: 1. Resident #20 expired on 01/19/17. A review of Resident #20's Patient Trust Statement for the period of 01/01/17 through 05/01/17 revealed a cash balance of $593.76 on 01/09/17. Checking interest of $0.01 was credited to the account on 01/25/17 with an ending balance of $593.77. An account entry dated 04/10/17 revealed the account was closed with a debit amount of $593.77 and an ending balance of $0.00. Review of a copy of a signed facility check dated 04/10/17, check number 11114 and paid to the estate of Resident #20, revealed the amount of $593.77. An interview on 04/13/17 at 2:45 with the	F 160	The Laurels of Hendersonville wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is 05/10/2017. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of 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. 1.Expired residents' #20, #50 and #144 personal fund accounts entire balance was forwarded to the Clerk of Court or estate on 4/13/2017. No negative outcome resulted. 2.All discharged residents' personal fund accounts were audited to ensure the	5/10/17

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

Electronically Signed | 05/06/2017

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F 160	Continued From page 1 Business Office Manager (BOM) revealed she had started in her position in September, 2016. She stated if a deceased resident had an account balance and the facility was awaiting receipt of payment from secondary insurance sources, trust funds could be converted to be applied as payment for any outstanding room and board charges still due. She stated this was how she was trained and believed it was a corporate policy. An interview on 4/13/17 at 2:50 PM with the Administrator revealed she was not sure if it was facility or corporate policy to withhold trust fund balances after a resident's death but she would call the corporate office for information. A second interview on 04/13/17 at 3:06 PM with the Administrator revealed the BOM had misunderstood the policy regarding personal trust funds, stating that upon death the trust fund accounts must be closed out immediately. She stated she also had not known this, but that checks would be mailed out this week. 2. Resident #58 expired on 01/07/17. A review of Resident #58's Patient Trust Statement for the period of 01/01/17 through 05/01/17 revealed a cash balance of $1,447.00 on 01/06/17. A patient liability charge was debited on 01/09/17 for $909.00 with an ending balance of $538.00. Another patient liability charge was debited on 01/11/17 for $400.00 with an ending balance of $138.00. An account entry dated 04/10/17 revealed the account was closed with a debit amount of $138.00 and an ending balance of $0.00. Review of a copy of a signed facility check dated	F 160	entire balance of expired residents' personal fund accounts were forwarded to the Clerk of Court, Estate, or Resident 0n 4/13/2017. 3.Regional Business Office Manager in-serviced the Business Office Manager (BOM) in regards to the conveyance of personal funds upon Discharge, eviction, or death, in accordance with State law on 04/13/2017. Business Office Manager (BOM) will compare census to discharged residents' weekly. at this time BOM will close all opened discharged residents' personal fund accounts and disperse funds in accordance with State law. A QA monitoring tool will be utilized to ensure ongoing compliance with personal fund accounts balance being forwarded to the resident, Clerk of Court, or estate within 30 days of discharge. The Regional Business Office Manager will review all opened and closed residents' personal fund accounts to assure all discharged residents' personal funds have been dispersed in accordance with State law, weekly x4 weeks, then monthly X3 months and ongoing until resolved by Quality Assurance Committee. 4.Findings will be reviewed with the Quality Assurance Committee monthly x3 months	

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F 160	Continued From page 2 04/10/17, check number 11113 and paid to the facility, revealed the amount of $138.00. An interview on 04/13/17 at 2:45 with the Business Office Manager (BOM) revealed she had started in her position in September, 2016. She stated if a deceased resident had an account balance and the facility was awaiting receipt of payment from secondary insurance sources, trust funds could be converted to be applied as payment for any outstanding room and board charges still due. She stated this was how she was trained and believed it was a corporate policy. An interview on 4/13/17 at 2:50 PM with the Administrator revealed she was not sure if it was facility or corporate policy to withhold trust fund balances after a resident's death but she would call the corporate office for information. A second interview on 04/13/17 at 3:06 PM with the Administrator revealed the BOM had misunderstood the policy regarding personal trust funds, stating that upon death the trust fund accounts must be closed out immediately. She stated she also had not known this, but that checks would be mailed out this week. 3. Resident #144 expired on 01/03/17. A review of Resident #144's Patient Trust Statement for the period of 01/01/17 through 05/01/17 revealed an opening cash balance of $105.94. Two debits for the beauty shop, each debit for $15.00, were posted to the account with an ending balance of $75.94. An account entry dated 04/10/17 revealed the account was closed with a debit amount of $75.94 and an ending balance of $0.00.	F 160	and ongoing until resolved by the Quality Assurance Committee to ensure ongoing compliance with further education, monitoring, or appropriate action if indicated.	

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F 160	Continued From page 3 Review of a copy of a signed facility check dated 04/10/17, check number 11117 and paid to the estate of Resident #144, revealed the amount of $75.94. An interview on 04/13/17 at 2:45 with the Business Office Manager (BOM) revealed she had started in her position in September, 2016. She stated if a deceased resident had an account balance and the facility was awaiting receipt of payment from secondary insurance sources, trust funds could be converted to be applied as payment for any outstanding room and board charges still due. She stated this was how she was trained and believed it was a corporate policy. An interview on 4/13/17 at 2:50 PM with the Administrator revealed she was not sure if it was facility or corporate policy to withhold trust fund balances after a resident's death, but she would call the corporate office for information. A second interview on 04/13/17 at 3:06 PM with the Administrator revealed the BOM had misunderstood the policy regarding personal trust funds, stating that upon death the trust fund accounts must be closed out immediately. She stated she also had not known this, but that checks would be mailed out this week.	F 160		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		5/10/17

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F 323	Continued From page 4 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with resident and staff, the facility failed to provide an environment free of hazards by leaving a half full bottle of flammable chemical unattended on the bed side table accessible by residents. This was evident in 1 of 30 rooms observed. (Resident #42's room) Finding included: Resident #42 was admitted to the facility on 12/05/16 with diagnoses that included hypertension, hemiplegia, and depression. The most recent annual Minimum Data Sheet (MDS) dated 03/01/17 indicated Resident #42 was cognitively intact and required the assistance of 1	F 323	1.The half full bottle of rubbing alcohol observed sitting on Resident #42 bedside table was removed. No negative outcome resulted. 2.All Resident rooms were audited to ensure an environment free of hazards on 04/10/2017. 3.Staff Development Coordinator will in-service all staff regarding the proper procedure to take when hazardous items are found in the residents' environment. 4.During the Admission process	

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F 323	Continued From page 5 to 2 persons for most of the activity of daily living (ADL). Further review revealed Resident #42's vision was moderately impaired and had a history of colostomy. Review of Resident #42's care plans, physician's orders, and resident assessment on 04/10/17 at 5:05 PM did not reveal any documentation related to the use or self-administration of rubbing alcohol. During an observation on 04/10/17 at 8:49 AM, one half full bottle of rubbing alcohol was noted sitting on the bed side table next to the bed of Resident #42. In a subsequent observation conducted on 04/10/17 at 4:50 PM, the half full bottle of rubbing alcohol was observed sitting on the same bed side table. Resident #42 allowed the surveyor to smell the content of the bottle and it was confirmed to be rubbing alcohol. The content was consistent with the label of the bottle. Review of the label of the rubbing alcohol revealed the following warning statement: "Flammable. Irritant. Avoid exposure to the skin. In case of ingestion contact a poison control center immediately." During an interview conducted on 04/10/17 at 5:14 PM, Resident #42 confirmed he owned the bottle of rubbing alcohol but refused to disclose the source and the purpose of the rubbing alcohol to the surveyor. On 04/10/17 at 5:16 PM an interview was conducted with Nurse #3 who stated she was not aware of the bottle of rubbing alcohol in Resident	F 323	all guest and/or responsible party will be notified of the Laurels of Hendersonville's procedures to maintain an environment free of hazards. During the Admission process Nursing staff will complete an inventory checklist to ensure no hazardous materials are observed in guest belongings. 5.Resident Rooms Audit tool will be completed by department heads and/or Manager on Duty to ensure the residents' environment is free of hazards, daily x2 weeks, then 5 times per week x4 weeks, then 1 time per week x3 months and ongoing until resolved by Quality Assurance Committee. Additional in-servicing and/or counseling will be provided to staff/guest/families that are not compliant with the procedure for providing an environment free of hazards. 6.Findings will be reviewed with the Quality Assurance Committee monthly x3 months and ongoing until resolved by the Quality Assurance Committee to ensure ongoing compliance with further education, monitoring, or appropriate action if indicated.	

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F 323	Continued From page 6	F 323		

#42's room and the purpose of this chemical. According to Nurse #3, the bottle of rubbing alcohol was not supposed to be freely accessible by any residents in the facility as it could be hazardous. Resident #42 refused to tell her anything about the rubbing alcohol. Nurse #3 stated she was going to get some other staff to address the issue immediately.

During an interview conducted on 04/11/17 at 9:37 AM, Nurse #3 stated that the rubbing alcohol had been removed from Resident #42's bed side table on 04/10/17 evening.

Observation of Resident #42's room on 04/11/17 at 9:38 revealed the bottle of rubbing alcohol was no longer on the bed side table.

On 04/12/17 at 9:10 AM an interview was conducted with Nurse #4 who stated he did not know how long the bottle of rubbing had been sitting on Resident #42's bed side table and who brought it in for Resident #42. According to Resident #42, he used the rubbing alcohol to remove the adhesive substances on his skin from colostomy appliance. The nursing staff removed the bottle of rubbing alcohol from the bed side table and offered education for safe storage of chemical. Resident #42 agreed to look for a different way for adhesive substance removal as it could cause skin irritation.

During an interview conducted on 04/13/17 at 3:15 PM the Director of Nursing (DON) stated that it was her expectation to provide an environment free of hazards in the facility. As a hazardous chemical, the rubbing alcohol should not be accessible to any resident without physician's order.

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F 323	Continued From page 7 On 04/13/17 at 3:41 PM an interview was conducted with the Administrator. She stated that without physician order, no residents were allowed to have any hazardous chemical such as rubbing alcohol in their room if it was not locked up or accessible to other residents.	F 323		
F 360 SS=D	483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to serve a balanced meal to 1 of 3 sampled residents on a puree diet with known food preferences. (Resident #37) The findings included: Resident #37 was admitted to the facility 03/10/15 with diagnoses which included Alzheimers dementia with delusions. The current Minimum Data Set assessment dated 04/04/17 assessed Resident #37 with moderate cognitive impairment. Physician orders for Resident #37 included to serve a puree diet. The latest Care Area Assessment dated 10/19/16 for the area of nutrition noted the weight of Resident #37 was within normal limits and to continue on a puree diet with 2 slices of white	F 360	1.Resident #37 was immediately provided a puree meat and a puree vegetable. 2.All trays of residents receiving a puree meal, were audited to ensure guest Were provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special needs, taking into consideration the preferences of each resident on 4/13/2017. Dietary Department will keep frozen puree alternates in stock to ensure residents with a puree diet is provided a well-balanced diet that meets his or her daily nutritional needs, and to ensure residents' preferences are being	5/10/17

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F 360	Continued From page 8 bread. The current care plan for Resident #37 last updated 01/24/17 included the following problem areas: -At nutritional and dehydration risk related to requires one assist to eat, anemia, therapeutic diet, mechanically altered diet, use of diuretic, use of psychotropics and dental issues. The approaches to this problem area included provide diet preferences and offer substitutes as needed and provide diet per order. -Potential for impaired communication related to cognitive deficits. The last care conference for Resident #37 (with family in attendance) dated 01/26/17 noted "care plan team met to discuss plan of care" and "dietary likes and dislikes discussed, dietary choices and alternatives discussed, will continue with current plan of care." The planned menu for the lunch meal on 04/13/17 was pork roast, potatoes and cabbage. The spread sheet for the preplanned menu indicated the lunch meal service for a puree diet should consist of 3 ounces of pork, 1/2 cup of potatoes and a 1/2 cup of cabbage. Observations of the steam table prior to start of lunch meal service noted puree food items available for the lunch meal service were puree pork, puree potatoes and puree cabbage. Prior to start of the lunch meal service the tray card of Resident #37 was reviewed and included on the tray card was a dislike of pork and cabbage. The diet listed on the tray card for Resident #37 was puree. The pork and cabbage were highlighted in yellow on the black and white tray card for Resident #37. The lunch tray line was observed from the start	F 360	met at all times. 3.All dietary staff will be in-serviced by the Dietitian in regards to providing an alternate for all consistencies of diets based on the residents' preference to ensure all residents are provided a well-balanced diet that meets his or her daily nutritional and special needs. 4.A QA monitoring tool will be completed by Dietary Manager to ensure ongoing compliance with guest who receive a puree diet is provided a well-balanced diet that meets his or her daily nutritional needs, while taking into consideration the preferences of all residents. The QA monitoring tool will monitor 5 puree diet tray's per day x2 weeks, then 5 puree diet tray's 5 times per week x2 weeks, then 5 puree diet tray's 3 times per week x2 weeks, then 5 puree diet tray's 1 time per week x2 weeks, then 5 puree diet tray's 1 time per month ongoing. 5.Findings will be reviewed with the Quality Assurance Committee monthly x3 months and ongoing until resolved by the Quality Assurance Committee to ensure ongoing compliance with further education, monitoring, or appropriate action if indicated.	

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F 360	Continued From page 9	F 360		

on 04/13/17 at approximately 12:00 PM through the time the tray for Resident #37 was plated. The dietary aide in the first position on the tray line was observed to review the tray cards, call out the diet and any dislikes/allergies pertaining to the lunch meal. The cook was standing to the immediate right of the dietary aide (in the first position) and was observed to plate the food based on what was called out by the dietary aide. At approximately 12:40 PM the tray for Resident #37 was plated. The dietary aide in the first position called out "puree diet, dislike cabbage and pork, 2 slices white bread." The cook plated a serving of puree potatoes and gravy and 2 slices of white bread. The dietary aide in the second position (to the right of the cook) covered the potatoes and gravy with a lid and placed an individual serving of ice cream and a glass of water on the tray. The tray was placed on the food delivery cart along with other resident trays for delivery to the hall Resident #37 resided. The cart with trays (for the unit Resident #37 resided) left the kitchen at approximately 12:45 PM.

The Food Service Director was present when this lunch tray was observed in the room of Resident #37 on 04/13/17 at approximately 1:00 PM. Resident #37 was observed in bed, the head of the bed was in an upright position and an aide was observed in the process of assisting Resident #37 with positioning before the start of the lunch meal. The lunch tray was uncovered and the lunch tray was the same as what had been plated at the kitchen and consisted of whipped potatoes and gravy, 2 slices of white bread, an individual serving of ice cream and a glass of water. Attempts to ask Resident #37 about the lunch meal were unsuccessful with no response to questions asked. The Food Service

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F 360	Continued From page 10 Director observed the food on the lunch tray served to Resident #37 and commented it was unacceptable and was lacking in meat and a vegetable. The Food Service Director stated the tray cards were typically reviewed by a dietary aide prior to the start of the meal service with any items listed as a dislike or allergy (that were on the planned menu) highlighted prior to start of the tray line. The Food Service Director stated ideally the information should be shared with the cook to ensure alternate food items were available; especially for residents on a mechanically altered diet. The Food Service Director returned to the kitchen and minutes later puree chicken and puree mixed vegetables were brought to Resident #37. The nursing assistant feeding Resident #37 the lunch meal stated Resident #37 had to be fed her meals and that her intake varied on a daily basis. When Resident #37 was finished with the lunch meal she had consumed a few bites of the potatoes, puree chicken and puree mixed vegetables. On 04/13/17 at approximately 1:53 PM the cook that plated the food for Resident #37 at the lunch meal stated he typically would have something available as an alternate for all consistencies and could not explain why he only served Resident #37 potatoes and gravy at the lunch meal. On 04/13/17 at 4:00 PM the Administrator stated she expected residents to be served a nutritious meal with alternate food items if the food on the planned menu was a known dislike.	F 360		
F 460 SS=D	483.90(e)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY (e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;	F 460		5/10/17

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F 460	Continued From page 11 (e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with resident and staff, the facility failed to provide full visual privacy for resident occupied semi-private room. This was evident in 1 of 4 resident halls (100 Hall). Finding included: Resident #11 was admitted to the facility on 08/23/13 with diagnoses that included dementia, anxiety, and depression. The most recent annual Minimum Data Sheet (MDS) dated 03/04/17 indicated Resident #11 had mild cognitive impairment and required the assistance of 1 person for all activity of daily living (ADL). Further review revealed Resident #11 was with adequate vision. Review of Resident #11's care plans and care conference minutes dated 06/16/16, 09/08/16, 12/8/16, and 03/16/17 did not reveal any documentation related to rejection of privacy curtain by Resident #11. During an observation on 04/11/17 at 3:42 PM, Resident #11's bed was observed without privacy curtain in her semi private bedroom. Further observation revealed that the track and hooks for the privacy curtain were in place. Resident #11's bed located closer to the entrance door. Without the privacy curtain, Resident #11 could be seen	F 460	1.Resident #11 privacy curtain was immediately hung to provide full visual privacy for resident. 2.All semi-private rooms were audited to ensure two privacy curtains were in place on 04/13/2017. 3.Staff Development Coordinator will in-service all staff regarding all semi-private rooms are to have two privacy curtains in place at all times to assure full visual privacy for residents. Environmental Service Director will in-service housekeeping staff regarding the facilities procedure for replacing privacy curtains needing to be laundered or replaced. 4.A QA monitoring tool will be completed by Environmental Service Director to ensure ongoing compliance of all semi-private rooms having two privacy curtains in place at all times. The QA monitoring tool will monitor all semi-private rooms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 460	Continued From page 12 when the door was opened. On the other hand, Resident #11's roommate whose bed located next to the window was observed with the privacy curtain in place. Subsequent observations revealed that the privacy curtain for Resident #11's bed was remained missing on the following dates and times: 04/12/17 at 8:21 AM, 04/12/17 at 4:36 PM, and 04/13/17 at 9:39 AM. During an interview conducted on 04/12/17 at 8:50 AM Resident #11 stated that she could not remember how long the privacy curtain had been missing. Without the privacy curtain, she could be seen directly whenever the door was opened and it bothered her. On 04/13/17 at 9:43 AM an interview was conducted with Nurse Aide (NA) #1 who stated she would normally check Resident #11's room to ensure the privacy curtain was in place. However, she had forgotten to do it in the past few days and she did not know how long the privacy curtain had been missing. During an interview conducted on 04/13/17 at 9:48 AM Nurse #1 stated that she did not work at 100 Hall on regular basis. She was scheduled to work at 100 Hall last Thursday and she could not recall whether the privacy curtain for Resident #11 was in place on that day. She added the housekeeping staff took down the privacy curtain for cleaning periodically. On 04/13/17 at 9:55 AM an interview was conducted with the Unit Manager. She acknowledged that the privacy curtain for Resident #11 had been missing in the past few	F 460	privacy curtain placement daily X2 weeks, then 5 times per week x2 weeks, then 3 times per week x2 weeks, then 1x per week x2 weeks, then 1 time per month ongoing. 5.Findings will be reviewed with the Quality Assurance Committee monthly x3 months and ongoing until resolved by the Quality Assurance Committee to ensure ongoing compliance with further education, monitoring, or appropriate action if indicated.	

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F 460	Continued From page 13	F 460		

days. It was her expectation for all the bed to be furnished with privacy curtain in order to provide full visual privacy at all time unless it was refused by the resident or had been stated otherwise in the care plan.

During an interview conducted on 04/13/17 at 9:58 AM Environmental Director (ED) stated that 2 sets of privacy curtains should be in place for all semi private room unless it was refused by the resident or had been stated otherwise in the care plan. The ED further stated that the environmental staff had conducted daily rounds to look for missing or dirty privacy curtains in the facility. The ED added the privacy curtain would be pulled down for cleaning whenever a resident was discharged, having room changes, when it was soiled, or due for a routine cleaning.

On 04/13/17 at 3:15 PM an interview was conducted with the Director of Nursing (DON). She stated it was her expectation for all the resident to have privacy curtain in place all the time to ensure full visual privacy unless it was refused by the resident or had been stated otherwise in the care plan or physician order.

During an interview conducted on 04/13/17 at 3:41 PM the Administrator stated that she would refer to the facility's privacy curtain policy for guidance regarding Resident #11's missing privacy curtain.

On 04/13/17 at 5:02 PM an interview was conducted with NA #2. She could not recall how long the privacy curtain was missing for Resident #11. Without the privacy curtain in place, NA #2 stated she was able to provide care for Resident #11 without compromising her privacy by pulling

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F 460	Continued From page 14 her roommate's privacy curtain and closing the door at the same time. Anyone who needed to come into the room had to knock on the door. NA #2 added Resident #11's roommate had no problem with that arrangement and Resident #11's privacy had never been compromised so far.	F 460		