Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036004	A. BUILDING _____ B. WING _____	R-C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and a complaint investigation on 09/06/22 through 09/07/22.	D 000	D066 /NCAC 13 .0305(h)(3) To Be incompliance with the Rule The facility immediately Removed the chain. The Admin met with all staff and enforced a hourly check to assure the chain is not on the door @ anytime after the Removal. The hourly check will be kept in the S.I.C's Chart to assure each staff is signing off hourly on each shift. The RCD will check the signed sheets daily to assure	
D 066	10A NCAC 13F .0305(h)(3) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (3) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys; and This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that all exit doors were easily operable, by a single hand motion, from the inside at all times without keys related to exit double doors chained and locked together. The findings are: Observation of the facility's single hallway on 09/06/22 at 12:17pm revealed: -There was one exit doorway at the end of the hallway with double doors. -The doors' metal push bars were chained together with a metal chain and padlock preventing the doors from opening. -There were twenty resident rooms on the hallway. Review of the facility's fire evacuation diagram revealed residents in rooms 5 - 15 would evacuate through the exit doors at the end of the hall in the event of a fire.	D 066		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator (X6) DATE: 10/17/22

Shannon B Cameron

Reviewed and acknowledged LSB 10/20/22

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D 066	Continued From page 1 Review of the facility's census on 09/06/22 at 12:20pm revealed there were 14 residents residing in rooms 5 - 15. Interview with a medication aide (MA) on 09/06/22 at 12:28pm revealed: -A resident had "jammed" the doors and they would not shut. -The padlock had been on the doors for about six weeks. -She did not know who had placed the padlock on the doors. Interview with a maintenance staff on 09/06/22 at 12:50pm revealed: -He placed the chain and padlock on the doors to prevent a resident that used a walker from leaving the facility and "hurting" himself. -The Administrator had instructed him to place the padlock on the doors. -The padlock had been placed two days ago (09/04/22). -If there was a fire in the hallway he would just go through the fire and unlock the doors to evacuate the residents. Interview with the Resident Care Coordinator (RCC) on 09/06/22 at 2:32pm revealed: -She did not know how long the exit doors had been locked. -She did not think they had been locked yesterday (09/05/22). -The exit doors were not shutting and someone had asked the maintenance staff to fix it. -If there was a fire in the hallway she would bring the residents away from the hall to the living room. -If she could not get down the hallway in the event of a fire she would hope the residents	D 066	The facility is uncompliance this was completed on 9/8/22. The Admin called the Fire Marshall (Jim Landis) to schedule a fire safety training class for staff and Residents to assure that all staff is aware and can stay in compliance. The Class will be Scheduled @ MR Landis (Fire Marshall) earliest time in Nov. Because he was Booked with the school systems for the month of October.	

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D 066	Continued From page 2	D 066	All staff will attend the training to assure the facility is in compliance. Documentation of the class will be kept in the Admin's office for Review @ all times.	

would break a window in their rooms to get out of the facility.
-She would not know how to get the one resident with a diagnosis of dementia out of the facility if she could not get down the hallway.

Interview with a second shift MA on 09/06/22 at 4:01pm revealed:
-He did not know who had placed the chain and padlock on the exit doors but it had been there a few months.
-He knew the residents on the back half of the hall closest to the exit doors would evacuate through that doorway in the event of a fire.
-If there was a fire on the hallway there would be no way to get those residents out of the facility.
-He knew it was a fire safety hazard to lock the exit doors but he did not bring it to management's attention.

Interview with a personal care aide (PCA) on 09/06/22 at 4:06pm revealed:
-The exit doors at the end of the hallway had been locked for two months.
-She thought the doors were broken and that is why the padlock was placed on them.
-If there was a fire on the hall the residents that should evacuate out the hallway exit doors would not be able to get out.

Telephone interview with the local Fire Marshall on 09/06/22 at 2:34pm revealed:
-Locking the hallway exit door was a major fire hazard that could lead to loss of life.
-He was concerned about the locked exit doors and would come to the facility today (09/06/22).

Interview with the local Fire Marshall on 09/06/22 at 3:05pm revealed:
-The exit doors at the end of the hallway were a

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D 066	Continued From page 3	D 066		

required means of egress at the end of the corridor.
-The exit doors were part of the facility's fire evacuation plan.
-The Fire Marshall would send the facility a letter that the locked doors were in violation of the fire code.

Interview with the Administrator on 09/07/22 at 8:30am revealed:
-She knew the exit doors at the end of the hallway should not be locked.
-A resident had been allowing homeless people to come into the facility and the padlock had been placed to prevent that.
-The lock had been placed on the doors at the end of 2021.
-She thought a maintenance staff had placed the lock on the doors but was not sure.
-All staff had received fire safety training.

Review of the facility's fire and disaster plan revealed keep all exits clear at all times.

The facility failed to ensure that all doors were easily operable from the inside related to a chain and padlock around the push bars on the two side by side exit doors at the end of the hallway which would prevent 14 residents in rooms 5 - 15 from evacuating in the event of a fire. This failure placed the residents at substantial risk of serious physical harm and death and constitutes a Type A2 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/06/22 for this violation.

CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 7,

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D 066	Continued From page 4 2022.	D 066	D273/NCAC 13F.0902B To be incompliance with the Rule the facility will continue with the current Refusal policy. But if the med Aide @ anytime see a change in how the Resident is taking their medication, ie... (starts Refusing every so often But haven't normally) the Med Aide will notify the RCO and the MD immediately. The RCO / Med Aide will Document the MD's Response in the Resident's chart. The chart will Be Kept in the Nurses Station for Review @ all time for Review.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure referral and follow up with the physician for 1 of 3 sampled residents (Resident #1) related to not notifying the physician regarding his refusals of an antipsychotic medication to treat paranoid schizophrenia. The findings are: Review of Resident #1's current FL2 dated 03/04/22 revealed: -Diagnosis of paranoid schizophrenia. -There was an order for haloperidol 2mg/ml (a medications used to treat paranoid schizophrenia), 5ml by mouth three times daily. Review of Resident #1's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for haloperidol 5ml by mouth three times daily and scheduled to be administered at 6:00am, 12:00pm and 6:00pm.. -From 08/11/22 at 6:00pm to 08/30/22 at 6:00am there was documentation haloperidol 5ml was documented as refused 9 of 56 opportunities. Telephone interview with a second shift Medication Aide (MA) on 09/07/22 at 11:35am	D 273		

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D 273	Continued From page 5	D 273	This will start 9/8/22 immediately to assure the facility is in compliance.	

revealed:
-She was trained to inform the Resident Care Coordinator (RCC) if a resident refused or missed 3 consecutive doses of a medication.
-She did not inform the RCC that Resident #1 refused his haloperidol because he did not refuse three consecutive doses.
-Resident #1 did not usually refuse medications.
-If Resident #1's behaviors were out of character and he had intermittently refused some of his evening haloperidol she would have told that to the RCC.
-She did not inform the RCC that it was unusual for Resident #1 to refuse medications.

Interview with the RCC on 09/06/22 at 12:30pm and 09/07/22 at 11:04am revealed:
-Resident #1 never refused medications from her in August 2022.
-She was not aware Resident #1 refused any of his 6:00am or 6:00pm medications in August 2022.
-The MAs were trained to report medication refusals if 3 consecutive doses were refused.
-Resident #1's PCP was at the facility on 08/26/22 for a patient visit and medication review.
-She did not inform the PCP of the medication refusals because she was not aware of them and because the PCP had access to the Residents eMAR and she thought the PCP reviewed medications.

Telephone interview with Resident #1's PCP on 09/06/22 at 2:15pm revealed:
-She monitored Resident #1's medications and behaviors and adjusted medications as needed.
-Staff did not inform her of any medication refusals when she was at the facility on 08/26/22.
-She had access to the eMAR system but she did not use it to monitor medication compliance, she

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D 273	Continued From page 6	D 273		

used it to confirm the eMAR entry matched the prescribed dose.
-She did not review Resident #1's medication compliance when she was at the facility on 08/26/22.
-She expected the RCC to inform her if a medication was being refused.
-If staff had informed her that medications were being refused intermittently she would have reviewed his behaviors and since his behaviors were very stable, she would not have been concerned or done anything differently.

Interview with the Administrator on 09/07/22 at 11:04am revealed:
-She did not know Resident #1 refused any medications in August 2022.
-The RCC was on the medication cart daily and conducted audits weekly.
-When a cart audit was conducted the eMAR was compared to the medications in the medication cart.
-The RCC referred to trends in behaviors in addition to trends in medication refusals.
-If Resident #1's behaviors had changed she would have informed the PCP regardless of the medication refusal criteria.

D914 G.S. 131D-21(4) Declaration of Residents' Rights — D914

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:
4. To be free of mental and physical abuse, neglect, and exploitation.

This Rule is not met as evidenced by:
Based on observation, interview and record

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D914	Continued From page 7	D914	D914 / 10 0CC16 Please Refer to page 1 & 2	

review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to a chained and locked exit door.

The findings are:

Based on observations, interviews, and record reviews, the facility failed to ensure that all exit doors were easily operable, by a single hand motion, from the inside at all times without keys related to exit double doors chained and locked together. [Refer to Tag 66 10A NCAC 13F .0305(h)(3), Physical Environment (Type A2 Violation)].