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
	MHL092-954	A. BUILDING: _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE RESIDENTIAL SERVICES	1408 SILVER VALLEY DRIVE KNIGHTDALE, NC 27545

(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
V 000	INITIAL COMMENTS An annual survey was completed 5/15/15. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living.	V 000	DHSR - Mental Health JUN 28 2018 Lic. & Cert. Section	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108	V108 This deficiency will be corrected by the following actions: a. The provider will be trained on physician orders related to the use of a glucometer machine, lancets and test strips. b. The MAR shall be kept current and medication administered will be recorded immediately after administration. c. The provider will be monitored by the monitoring agency d. The provider will be trained annually.	07.14.2018

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deanna Rose	License Holder	

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V 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on observation, record review and interview, the Manager failed to assure she obtained training to meet the needs of 1 of 2 clients (#1). The findings are: Observation on 5/15/18 at approximately 11:00 AM of client #1's medications and supplies revealed a glucometer, lancets and test strips were present. Review on 5/15/15 of client #2's record revealed: - an admission date of 8/16/17 - an Individual Support Plan dated 8/16/17 with diagnoses including Anxiety, Moderate Mental Retardation and Type II Diabetes - a physician's order dated 4/20/18 had instructions to check client #1's blood sugar once daily Review on 5/15/18 of the Manager's personnel record revealed no evidence of training in diabetes management. During an interview on 5/15/18, the Manager reported client #1's blood sugar was checked daily. The Manager reported she did not have any evidence of formal training in assisting people with diabetes.	V 108		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS	V 113		

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V 113	Continued From page 2 (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113	V113 *This deficiency will be corrected by the following actions:* a. *All consents will be added to consumers charts.* b. *All consents will be signed by guardians.* c. *The provider will ensure that all consents are updated annually.* e. *The provider/consumer charts will be monitored by the monitoring agency*	07.14.2018

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V 113	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interviews, the Manager failed to assure signed statements from guardians granting permission to seek emergency care from a hospital or physician was maintained in 2 of 2 client records (#1, #2). The findings are: Review on 5/15/15 of client #1's record revealed: - an admission date of 8/16/17 - an Individual Support Plan dated 8/16/17 with diagnoses including Anxiety, Moderate Mental Retardation and Type II Diabetes and Congestive heart Failure - no evidence of consent to seek emergency medical care Review on 5/15/15 of client #2's record revealed: - an admission date of 2007 - an Individual Support Plan dated 4/1/17 with diagnoses of Moderate Intellectual Disability - no evidence of consent to seek emergency medical care During an interview on 5/15/18, the Manager reported she did not a consent for the clients.	V 113		

Community Alternatives – North Carolina
Inservice/Training Signature Sheet

TITLE OF TRAINING: Medication Administration Day 2

DATE: 6/22/18 LOCATION: Main Office DURATION: 1hr.

SIGNATURE OF FACILITATOR: [signature] RN

PRINTED NAME OF FACILITATOR: Elonda Womble, RN

BRIEF DESCRIPTION OF TRAINING: SIGNS AND SYMPTOMS OF ILLNESS/ DIABETES MANAGEMENT/GLUCOSE MONTIROING

Participant's Signature	Sign Name	Score	Service Site
[redacted]	[redacted]	Pass Fail %	AFL Provider
		Pass Fail %	AFL Consumer
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
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		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	
		Pass Fail %	

BLOOD SUGAR LEVEL CHART

	FASTING	JUST ATE	3 HOURS AFTER EATING
NORMAL	80-100	170-200	120-140
PRE-DIABETIC	101-125	190-230	140-160
DIABETIC	126+	220-300	200+

Community Alternatives North Carolina
Consent for Emergency Medical/Dental Services and Medications

Name: [redacted] Effective Date: _____

Record [redacted] Medicaid #: [redacted]

I hereby provide consent for Community Alternatives North Carolina to seek emergency services for the above named individual in the even of a medical, dental or psychiatric emergency. I further consent that a physician may provide treatment deemed necessary and emergent until I can be contacted. I anticipate that Community Alternatives North Carolina will contact me as soon as possible upon the occurrence of a medical, dental or psychiatric emergency. I understand Community Alternatives North Carolina may disclose confidential information to the physician or health care provider who is providing the emergency medical services.

I also provide consent for medications such as antibiotics to be given prior to my verbal or written consent. I anticipate that Community Alternatives North Carolina will contact me as soon as possible to obtain my consent for the prescribed medication.

[redacted]

Parent / Guardian Signature

Date 6/25/18

Guardian Phone

Qualified Professional

Date 6/25/18

Community Alternatives North Carolina
Consent for Emergency Medical/Dental Services and Medications

Name:	[redacted]	Record #:	[redacted]	Medicaid#:	[redacted]

I hereby provide consent for Community Alternatives North Carolina to seek emergency services for the above named individual in the even of a medical, dental or psychiatric emergency. I further consent that a physician may provide treatment deemed necessary and emergent until I can be contacted. I anticipate that Community Alternatives North Carolina will contact me as soon as possible upon the occurrence of a medical, dental or psychiatric emergency. I understand Community Alternatives North Carolina may disclose confidential information to the physician or health care provider who is providing the emergency medical services.

I also provide consent for medications such as antibiotics to be given prior to my verbal or written consent. I anticipate that Community Alternatives North Carolina will contact me as soon as possible to obtain my consent for the prescribed medication.

[redacted]

Parent / Guardian Signature

Date 6-23-18

Guardian Phone

Jennifer Keay

Qualified Professional

Date 6/23/18

June 26, 2018

Toni Rankin-Green
Facility Survey Consultant I
NC Department of Health and Human Services
Mental Health Licensure and Certification section
Division of Health Service Regulation

RE: **Plan of Correction for Annual Survey Conducted on May 15, 2018**
Rose Residential Services
1408 Silver Valley Drive, Knightdale, NC 27545
MHL# 092-954
Email **DMROSE180@GMAIL.COM**

Dear Rankin-Green

We appreciate the courtesy extended by you while surveying the **Rose Residential Services, Knightdale, North Carolina.**

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey conducted On **May 15, 2018**, it will be completed **July 14, 2018.**

We are committed to providing the highest possible care for the people we serve at Kennon Drive Home.

If you have questions, please contact Deanna Rose, 919.649.1643

Sincerely,

Deanna Rose,
Rose Residential Services
408 Silver Valley Drive, Knightdale, NC 27545
MHL# 092-954
Email **DMROSE180@GMAIL.COM**

Community Alternatives – NC
Southeast Region
1001 Navaho Drive Suite 101
Raleigh, NC 27609
Phone: 984-205-2630
FAX: 984-205-2643

FAX

To: Toni Rankin **From:** Deanna Rose

Fax: 919-715 3078 **Pages:** 9

Phone: 919-355-3795 **Date:** 6/26/18

Re: **CC:**

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: