STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-267	A. BUILDING: _____ B. WING _____	R 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HOME	209 ROSE STREET CARY, NC 27511

(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 and follow up and complaint Survey was completed on 04/09/19. The complaints were substantiated (Intake #NC00149329 and #NC00148457). Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
`Based on record review and interview, the facility failed to implement strategies for 1 of 3 audited clients (#1). The findings are:

Review on 4/5/19 of client #1's record revealed:
- admission date 1/15/97
- diagnoses including Severe Intellectual and Developmental Disabilities, Cerebral Palsy and Seizure Disorder
- her parents are co-guardians and both need to be contacted for concerns about her care
- a treatment plan dated 11/1/18 with:
-"Long range goal #3 [Client #1] is safe and free from harm at home and in the community. [Client #1] has a tendancy to walk too fast when in the community. Short range goal: [Client #1] will walk slow in the community with assistance from staff. ...Staff's action: Staff will provide physical assistance with walking at a slower pace."
- an update to the treatment plan dated 2/11/19 with:
- "[Client #1]'s gait is unsteady and it is important that there is someone close to her to prevent falls or injury.'

Review on 4/5/19 of a "General Events Report" dated 1/2/19 revealed:
"...After coming back into the group home from an outing [client #1] tripped over her own feet walking on the sidewalk and scrapped her face on the concrete...Incident occurred causing [client #1] to skin the side of her face...the incident was observed...at 12:30pm as clients were getting out of the van to enter the group home. [Client #1] was walking inside when she

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V 112	Continued From page 2	V 112		

tripped over her own feet and fell to the ground. Staff helped the client to her feet and brought her inside to clean the scratches and bandage the scratches. [Program Coordinator] was notified and [Qualified Professional] was notified. [Client #1]'s parents were notified of the incident that occurred. Assessment completed by [RN/NS] (Registered Nurse/Nursing Supervisor) on 01/02/19 at 2:45pm. Upon arrival at the residence, [client #1] was sitting at the dining room table with her mother sitting to her left. Writer noted two large abrasions which appeared to be from a sliding impact to her face and a swollen mid upper lip. Her mid upper lip was noted to be slightly split, just enough for dried blood to be present. The abrasion above the client's right eye was oval in shape and extending from mid eyebrow out towards outer eyebrow measuring approximately 2.5 inches by 1 inch. The abrasion below right eye was carefully palpated, no movement of the bone was noted. Both abrasions were noted to be bright red without active bleeding. A modified neuro check was performed with her mother's assistance. PERRLA (pupils equal, round, reactive to light and accommodation). Client was able to grab objects with both hands but was unable to follow simple commands for a complete neuro check. Client was behaving as usual per present staff and mother without any change in mentation. Client showed no signs of being sleepy and no vomiting was present. The writer cleaned the abrasions and lip with mild soap and water and dried the areas with gauze with clients mothers assistance. TAO (triple antibiotic ointment) was applied to both abrasions being very careful to avoid the clients eye. Both upper and lower teeth were examined and checked. No looseness, chips or bleeding noted. With the staff and mother present I reviewed signs and symptoms

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V 112	Continued From page 3 of a concussion, signs and symptoms of wounds infection, when to call 911 vs NOC (Nurse on call). Instructed to call NOC for any changes in behavior, active bleeding or any other symptoms, no matter how minimal. The DON/NOC (Director of Nursing/Nurse on call) was notified of the writer's nursing assessment and at the time it was decided an orbital x-ray/scan would be appropriate. The DON/NOC was to follow up immediately with client's mother and the QP. DON/NOC will continue to monitor. Corrective Actions Taken: [Qualified Professional] (here identified as the Group Home Manager) and the mother of [client #1] was contacted. The abrasion was cleaned and taken care of by nursing. Staff was inserviced on making sure that they hold [client#1]'s hand when she is walking on uneven surfaces...." Review on 4/9/19 of a handwritten report from staff #1 present during this incident revealed: - "...I [staff#1] was inside the house while the other staff [#2] was walking behind [client#1] outside of the home. [Client #1] tripped over her boot and fell to the ground. I know this is so because I looked out of the living room window as [client #1] was walking into the home before falling to the ground..." - no documentation of client #1 being physically assisted while walking into the facility Review on 4/9/19 of a handwritten report from staff #2 present during this incident revealed: "...[Client #1] was walking inside when she tripped over her own feet and fell to the ground and scraped her face..." - no documentation of client #1 being physically assisted while walking into the facility Review on 4/9/19 of the Quality	V 112		

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V 112	Continued From page 4 Assurance/Quality Improvement (QA/QI) Investigative Report revealed: "Conclusion by the QA/QI Department: "This incident was reviewed by all parties and staff have received in-service training by the residence manager. Staff are to ensure going forward, they hold the hand of the resident when she is walking on uneven surfaces. Staff followed procedures...in a timely manner...We will continue to monitor the resident to prevent an incident of this nature from occurring again." Review on 4/9/19 of a Plan of Protection dated 4/9/19, written and submitted by the Quality Assurance/Quality Improvement Manager (QA/QI) revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "(1) Ensure the staff will follow all guidance on safety for each consumer per their ISP (Individual Service Plan) or Treatment Plan. (2) Conduct a refresher course w/each staff to ensure they are following the goals on each consumer under their care. (3) Increase staffing levels to ensure at least 2 staff are present on each shift." Describe your plans to make sure the above happens. "(1) Staff meeting w/Rose location to discuss findings from this review. (2) Have staff sign documentation confirming their understanding of each goal/objective from ISP/Tx (treatment) Plan to ensure safety. (3) Monthly review of all incidents by QA/QI to determine if/when corrective action is needed." Client #1 was known to walk quickly with a pitched forward position. Her treatment plan called for staff to provide both verbal and physical	V 112		

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V 112	Continued From page 5 assistance to her when walking. On January 2, 2019 client #1 was walking without physical assistance and fell forward causing angry red abrasions both below and above her right eye and a split upper lip. These injuries were treated with first aid and although nursing staff recommended follow-up for a head wound at an urgent care facility, this was not done because the father/co-guardian had already removed the client from the facility and refused to have her seen. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 112		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum	V 290		

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V 290	Continued From page 6 of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure staffing was maintained to meet the needs of 3 of 3 audited clients (#1, #2 &#3). The findings are: Review on 4/04/19 of 3 of 3 audited clients records revealed ; - Client #1: - admission date 7/17/97 - diagnoses including severe intellectual and developmental disabilities (IDD),seizure disorder, Cerebral Palsy .	V 290		

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V 290	Continued From page 7 - she is non-verbal and needs physical assistance in walking - Client #2 - admission date: 1/27/97 - diagnose including Profound IDD, Petit Mal & Grand Mal Seizures - she is non-verbal and can be very aggressive/assaultive when agitated - Client #3: - admission date 1/27/97 - diagnose including Profound IDD, Seizure Disorder, Myclonic Hysarchthmia - He is non-verbal, needs a pureed diet and has PICA habits Observation on 4/8/19 between approximately 11:30am and 12:30pm of client # 4 revealed she used a wheelchair propelled by others and required assistance in feeding herself. Review on 04-05-19 of schedule documentation revealed single coverage on second shift on the following dates: -March 9,12,15,16,21,23,24,25,26,27,28,3, 2019 -April 2,3,4, 2019 During an interview on 4/5/19, a staff person reported the clients at this facility have extra needs. Client #4 requires 1:1 assistance and other clients have seizures and all need physical assistance in either walking, feeding themselves and/or hygiene. She stated it was very important to always have 2 staff on scheduled but the agency had not been able to do this because of being short of staff. During an interview on 4/04/19 the Program Coordinator reported that the expected staff ratio on second shift is 2:4 but this has not been	V 290		

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V 290	Continued From page 8 possible recently due to staff shortage. During interviews on 4/04/19 and 4/05/19 the Qualified Professional reported they are in interviews to find staffing to fill the vacant positions. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community	V 291		

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V 291	Continued From page 9	V 291		

inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to coordinate services with other qualified professionals and family members as indicated in the treatment plan for 1 of 3 audited clients (#1). The findings are:

Review on 4/5/19 of client #1's record revealed:
- admission date 1/15/97
- diagnoses including Severe Intellectual and Developmental Disabilities, Cerebral Palsy and Seizure Disorder
- her parents are co-guardians and both need to be contacted for concerns about her care
- a treatment plan dated 11/1/18 with a crisis plan section:
  - "...Who to call: In the event of a medical emergency, seek medical attention immediately. [Client#1]'s parents should be contacted. (contact information listed). Tammy Lynn Center program manager [name listed] should be contacted. Care Coordinator [name listed] should be informed of a crisis or emergency situation (contact info listed)..."

Review on 4/9/19 of meeting notes dated 2/1/19 revealed:
- client #1's father asked why he wasn't called for incident on 1/2/19. Client #1's mom replied that she told staff she would call the father. The father asked that he be called (by Tammy Lynn staff) no matter what mom says. The Alliance Care Coordinator reported that she should have been called.

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V 291	Continued From page 10 Review on 4/9/19 of an email from the Alliance Center's Quality Management Grievance manager revealed: - "From what I can see, it looks like the provider documented the event correctly as a L1 (Level 1) incident. Even if she had gone for x-rays it would still fall in the L1 category.. Even though the treatment appears to have been provided by a licensed healthcare professional in-house, it doesn't appear to have required treatment by a licensed healthcare professional...If what the provider is stating is accurate, this wouldn't appear to match the crisis plan's requirement to notify the CC (Care Coordinator) if there was a "medical emergency." Review on 4/9/19 of the facility policy related to "Client Accident/Incident Reporting" revealed: - "...As indicated by parent call list, contact with parents regarding accidents/incidents shall be done by nursing staff if injury occurred which required treatment or if the accident/incident is medical in nature... Review on 4/5/19 of a "General Events Report" dated 1/2/19 revealed: "...After coming back into the group home from an outing [client #1] tripped over her own feet walking on the sidewalk and scrapped her face on the concrete...Incident occurred causing [client #1] to skin the side of her face...the incident was observed...at 12:30pm as clients were getting out of the van to enter the group home. [Client #1] was walking inside when she tripped over her own feet and fell to the ground. Staff helped the client to her feet and brought her inside to clean the scratches and bandage the scratches. [Program Coordinator] was notified and [Qualified Professional] was notified. [Client	V 291		

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#1]'s parents were notified of the incident that occurred. Assessment completed by [RN/NS] (Registered Nurse/Nursing Supervisor) on 01/02/19 at 2:45pm. Upon arrival at the residence, [client #1] was sitting at the dining room table with her mother sitting to her left. Writer noted two large abrasions which appeared to be from a sliding impact to her face and a swollen mid upper lip. Her mid upper lip was noted to be slightly split, just enough for dried blood to be present. The abrasion above the client's right eye was oval in shape and extending from mid eyebrow out towards outer eyebrow measuring approximately 2.5 inches by 1 inch. The abrasion below right eye was carefully palpated, no movement of the bone was noted. Both abrasions were noted to be bright red without active bleeding. A modified neuro check was performed with her mother's assistance. PERRLA (pupils equal, round, reactive to light and accommodation). Client was able to grab objects with both hands but was unable to follow simple commands for a complete neuro check. Client was behaving as usual per present staff and mother without any change in mentation. Client showed no signs of being sleepy and no vomiting was present. The writer cleaned the abrasions and lip with mild soap and water and dried the areas with gauze with clients mothers assistance. TAO (triple antibiotic ointment) was applied to both abrasions being very careful to avoid the clients eye. Both upper and lower teeth were examined and checked. No looseness, chips or bleeding noted. With the staff and mother present I reviewed signs and symptoms of a concussion, signs and symptoms of wounds infection, when to call 911 vs NOC (Nurse on call). Instructed to call NOC for any changes in behavior, active bleeding or any other symptoms, no matter how minimal. The DON/NOC (Director

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of Nursing/Nurse on call) was notified of the writer's nursing assessment and at the time it was decided an orbital x-ray/scan would be appropriate. The DON/NOC was to follow up immediately with client's mother and the QP. DON/NOC will continue to monitor. Corrective Actions Taken: [Qualified Professional] (here identified as the Group Home Manager) and the mother of [client #1] was contacted. The abrasion was cleaned and taken care of by nursing. Staff was inserviced on making sure that they hold [client#1's hand when she is walking on uneven surfaces...."

During an interview on 4/4/19 the Program Coordinator (PC #1) reported:

- she was informed of the incident soon after it happened at 12:30pm by the direct care staff working at the facility
- she contacted the Qualified Professional (QP) and then contacted client #1's mother
- after informing client #1's mother of the situation she told her she was also going to contact client #1's father
- client #1's mother insisted she be the one to contact the father and the PC agreed to this

During an interview on 4/9/19, client #1's mother (co-guardian) reported:

- she was informed of the incident at approximately 12:30pm on 1/2/19
- she arrived at the facility about 20 minutes later
- she insisted on being the one to contact her ex-husband (client #1's father) as he knew best how to present this to him calmly. She knew staff were supposed to contact him but she felt she could present it best.
- the nurse did not arrive until 2:45 and seemed "nonchalant and in no hurry"

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V 291	Continued From page 13 - she asked this nurse if client #1 needed to be taken to urgent care and she was told no - she left the facility at 4:45 and stated client #1's father took client #1 home between 5:00 and 5:30pm - after leaving she received a call from the QP who told her to take the client to urgent care - she told the QP client #1's father had already taken her home - she called client #1's father and told him about taking her to urgent care. She reported he refused to do so, saying he was taking her home. During an interview on 4/4 19, client #1's father (co-guardian) reported: - he was informed of this incident by his ex-wife (client #1's mother) - he was supposed to be informed by agency staff as outlined in her crisis plan - he arrived at the facility at approximately 2:30pm - client #1 did not appear stressed or traumatized but did have some lacerations on her face - was upset they did not take her to the hospital immediately - he took her home because he did not trust the care she would receive at the facility - believes the current administrators do not care about his daughter and do not follow protocol for contacting him - he did not take her to the hospital or for follow-up care because they (facility staff) had done first aid and she did not seem traumatized. He kept her home for 2 days without any problems. During an interview on 5/9/19, the nurse who treated client #1 reported: - on 1/2/19 at 12:30pm she was handling a	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-267	A. BUILDING: _____ B. WING _____	R 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HOME	209 ROSE STREET CARY, NC 27511

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V 291	Continued From page 14	V 291		

medical emergency at the main site in Raleigh
- she received a call from the residential QP about the incident
- she was handling another medical emergency and could not make it to the facility until approximately 2:45
- client #1's mother was present
- she assessed and treated the abrasions and instructed staff and the mother about concussions, contacting 911 or any changes in behavior
- she did not instruct anyone to get further care at an emergency or urgent care facility
- after leaving the facility she discussed situation with the DON who suggested client #1 be seen at urgent care for an orbital x-ray/scan
- she understood that the DON would continue with any further contacts or follow-thru a the DON was also the on-call nurse at that point

Note: The DON was on maternity leave and was not interviewed.

During an interview on 5/9/19, the Chief Program Officer (CPO) reported:
- she interviewed the DON by phone during her investigation of this incident
- the DON told her (CPO) that she instructed the QP to tell staff and mother that client #1 should be taken to urgent care for an X-ray.
- the mother (supposedly) refused and told the QP that the nurse needed to come to the facility
- the nurse went to the facility and treated the client as noted above, left and notified the DON of the status of situation.
- the DON again instructed the QP to tell staff/mom to have an x-ray done
- at that point client #1's father had arrived at the facility and had already taken her home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 291	Continued From page 15 - the DON reported she called the father's cell phone and left a message for him to call her "to discuss her recommendation" She stated she never received a return call from the father. - regardless of what client #1's mother says the Tammy Lynn Center should be the one to contact the father. - she added that unfortunately the father keeps changing his requirement for how he is contacted; he sometimes wants a call, then he wants email, then he goes back to wanting the call Review on 5/9/19 of the Quality Assurance/Quality Improvement Investigative Report revealed: "Conclusion by the QA/QI Department: "This incident was reviewed by all parties and staff have received in-service training by the residence manager. Staff are to ensure going forward, they hold the hand of the resident when she is walking on uneven surfaces. Staff followed procedures...in a timely manner. All notifications to guardian, supervisor and nursing staff occurred within the guidelines. We will continue to monitor the resident to prevent an incident of this nature from occurring again."	V 291		