

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

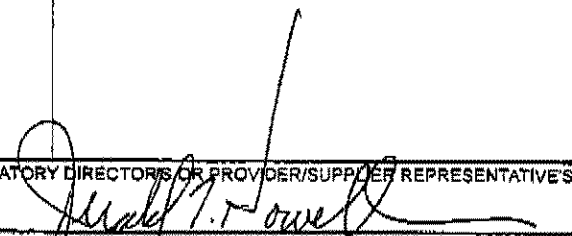
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2020
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NAME OF PROVIDER OR SUPPLIER ROSEANNE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ROSEANNE DR KINSTON, NC 28504
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(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)	(X6) COMPLETION DATE
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W 418	<p>CLIENT BEDROOMS CFR(s): 483.470(b)(4)(II)</p> <p>The facility must provide each client with a clean, comfortable mattress.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #3 had a comfortable mattress. This affected 1 of 3 audit clients. The finding is:</p> <p>Client #3 was in need of a new mattress.</p> <p>During observations in the group home on 3/4-5/2020, client #3's mattress was noted to have a large indentation or dip in the middle of it. The head and foot of the mattress were noticeably higher than the middle of the mattress.</p> <p>During an Interview on 3/5/2020, staff acknowledged the mattress had a noticeably large dip or sink in the middle. Additional interview indicated the dip in his mattress was likely because client #3 a little overweight.</p> <p>Interview on 3/5/2020 with the qualified Intellectual disabilities professional (QIDP) confirmed the mattress had a large dip in the middle and was also slanted to one side. Additional interview revealed the mattress was last purchased in 2012 and his current one needs to be replaced.</p>	W 418	<p>Doctor's order was obtained and mattress was ordered on 3/5/20. Mattress was delivered on 3/6/20. The conditions of the mattress will be assessed/monitored by GHM monthly.</p>	3/6/20
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By DHSR at 11:54 am, Apr 03, 2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>CEO/Member</i>	(X6) DATE <i>3-24-2020</i>
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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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Fax

To: MH Lic. and Cert. Section/ NC DHSR **From:** Melinda Gardner

Fax: 919-715-8078 **Pages:**

Phone: **Date:** 4/3/20

Re: **CC:**

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