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 _____	C 07/24/2020

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 A Complaint Survey was completed on 07/24/20. The Complaints were unsubstantiated (Intake #NC00166266 & #NC00166353) and substantiated (Intake #NC00167082). Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures	V 110		

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V 110	Continued From page 1 for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

This Rule is not met as evidenced by:
Based on record review and interview, one of five audited paraprofessional staff (#6) failed to demonstrate knowledge, skills and abilities to meet the needs of the population served. The findings are:

Review on 07/07/20 of staff #6's personnel record revealed the following:
- Hired 01/07/19
- Cardiopulmonary resuscitation (CPR) and First Aid training issued 03/18/18 with renewal date due 03/2020 (Note: Due to Coronavirus Pandemic, as of March 2020, CPR/First Aid cards had been extended 120 days past their date of expiration.)

During interview on 06/29/20, staff #6 reported she had been trained on the behavior plan as well as wound care for client #1.

Review on 06/30/20 of client #1's record revealed:
- Admission date 01/15/97
- Diagnoses included Severe Intellectual and Developmental Disabilities (IDD), Cerebral Palsy and Seizure Disorder
- Treatment plan dated 11/01/19 noted in July 2019, client was admitted to the hospital for cellulitis and atopical dermatitis (infected wound). In August 2019, client was seen by a wound care

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V 110	Continued From page 2	V 110		

specialist to assure proper healing and dressing. Client has a history of skin picking so a behavior plan was developed.

-Physician's order dated 07/22/19- client #1 "requires a right elbow splint and huge Posey hand mitts to be used until the open wound on her left arm heals..."

-Blank form entitled "Protective Device Order and Documentation of Use-Medical" listed "instructions for use Hand mitts and Right elbow splint are to be used at all times, until the wound on her left arm is healed. During use, check every 30 minutes and remove for 10 minutes, if used for 1 hour, 59 minutes. Remove for meals and bathing. Do not use Right elbow splint at night. Use Posey mitts on both hands at night."

Review on 07/08/20 of nursing notes between April-June 2020 provided by the Home Health Nurse for client #1 revealed the following regarding her wound care:

-04/29/20 visit...wound: length 4.4 cm, width 4 cm, depth 0.1 cm and size 17.6

-05/05/20 visit...wound: length 0.8 cm, width 1.4 cm, depth 0.1 cm and size 1.2

-05/11/20 visit...wound: length 2.8 cm, width 2.5 cm, depth 0.1 cm and size 7

Review on 06/30/20 of a level one incident report dated 05/12/20 at 1:40 PM completed by staff #5 and #6 revealed the following:

-On 05/10/20 at 3:30 AM, staff #6 went to put covers in the washing machine while client #1 was on the toilet. When staff #6 returned she observed client #1 "digging in her arm." Staff #6 immediately "tended to" client #1's arm. The arm was cleaned off and bandage replaced. Staff #6 called the House Supervisor who was the on-call contact person and forwarded her a photograph of client #1's arm.

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V 110	Continued From page 3 During interview on 06/30/20, staff #6 reported the following regarding 05/10/20: -She and staff #5 were on duty between 10:45 PM-7:00 AM. -Each staff had responsibility to monitor, change, bathe and dress two clients per shift. -She worked directly with client #1. -In the middle of the night, client #1 had a toileting accident, which required her to need to be bathed and changed. -She awakened client #1, walked her to the bathroom located inside her bedroom and proceeded to remove the soiled items (clothing, mittens, arm brace and attends). That night, client #1 had on the hard arm brace on her right arm. Client #1 sat on the toilet as she went to discard the attend in the trash. The trash can was located within 10 steps of client #1's bedroom. She estimated client #1 was left on the toilet between 10-60 seconds. Upon staff's return to the bedroom, client #1 had removed the bandage and "gotten into her arm." Client #1 had reopened the wound and "blood was everywhere." Protocol for re-dressing the wound was followed and supervisor was notified. -After the incident, management reminded her to monitor client #1 closer. She should not leave client #1 on the toilet without another staff monitoring. During interview on 06/30/20 and 07/07/20, staff #5 reported the following regarding 05/10/20: -She did not work with client #1. Staff #6 worked best with client #1 based on their history together. -The only assistance she provided was to gather the first aid supplies to re-dress client #1's wound.	V 110		

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V 110	Continued From page 4 During interview on 07/02/20, client #1's Home Health Care Nurse reported: -Between April 29th and May 5th 2020, client #1's wound to the left arm had healed significantly. During the May 5th visit, possibility of discharging client #1 from wound care was addressed with the on duty group home staff. -Client #1's time in treatment was extended a few weeks due to the 05/10/20 incident. Client #1's last day of home health service was 06/08/20. Review on 07/10/20 of the facility's Plan of Protection dated 07/10/20 submitted by the facility's QA/QI Compliance Manager revealed the following: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? 1. We will host a debriefing meeting with all Rose Home (community residence) staff (all shifts) on Thursday, July 9, 2020 at 9am. At this meeting we will review the deficiencies cited and plan of action. 2. We will ensure that staff will follow all policies and procedures to ensure proper supervision of consumers occurs. 3. Staff will complete a refresher course with Relias on how direct care paraprofessional are able to demonstrate the appropriate knowledge, skills and abilities that are required to accurately care for the population we serve. The course has been added to their training plan for completion by July 31st, 2020. Title Principles and Practices of Effective Direct Support Professionals. 4. TLC (Licensee) will continue to hold quarterly behavior review meetings where all behavior interventions plans are reviewed, updated or revised to meet the current needs of	V 110		

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V 110	Continued From page 5 the client. -Describe your plans to make sure the above happens. 1. We will increase the frequency of all staff meetings to improve the paraprofessionals level of competency with working with the population we serve. 2. The QA/QI Compliance Manager will complete virtual situational trainings. Each class will discuss scenarios that have or could occur while working in the home. Staff will be prompted to give their response. Redirection and additional training will be implemented based on these trainings. 3. We will implement round table discussions where discuss competencies and staff give input on topics to ensure we are protecting the health and safety of each client." Client #1 had diagnoses of Severe IDD, Cerebral Palsy and Seizure Disorder. She was mainly non-verbal except for vocalization of sounds. Since August 2019, client #1 had a history of reopening the wound on her left arm. A behavior plan that consisted of mittens to be worn on both hands at night and arm brace not used at night was implemented to limit client #1's range of motion to access the wound. On May 10, 2020, client #1 had to be bathed due to a toileting accident. Staff #6 left client #1 unsupervised on the bathroom commode located inside her bedroom. Client #1 did not have on her mittens which would have limited her access to the wound. The lack of staff oversight resulted in client #1 reopening her wound in size, width, and the extension of her wound care treatment is detrimental to client #1's health, safety and welfare. This constitutes a Type B rule violation. If the violation is not corrected within 45 days, an	V 110		

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V 110	Continued From page 6 administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 7	V 118		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to administer medications as prescribed for four of four clients (#1-#4) as well as assure one of four audited staff (Qualified Professional) were trained in Medication Administration. The findings are:

Review between 07/07/20 and 07/23/20 of the facility's Qualified Professional (QP)'s personnel record revealed the following:
-Hired:01/27/20
-Medication Administration Training: 02/14/20
-Training on Electronic Medication Administration System 07/09/20. No prior training noted

Review on 07/15/20 of the facility's "Medications-Administering to clients via [name of program]" policy revealed:
Facility utilized an electronic medication administration system from the pharmacy to administer, store and track clients' medications. Medications administration times are not associated with shifts but the time medications had been assigned to be passed. Only clients with medications due would be populated in the computer system at that time using a photo of the client. Medications must be scanned for the assigned administration time frame. Staff signed the MAR using their initials.

A. Review between 06/29/20 and 07/21/20 of client #1's record revealed:
-Admitted 01/27/97
-Diagnoses of Severe IDD (Intellectual

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V 118	Continued From page 8 Developmental Disability), Cerebral Palsy and Seizure Disorder -Physician's orders dated 06/01/20 listed medications which included: Atarax 10mg (milligram) one tablet three times a day (used to treat itching caused by allergies) Cerovite Tablet one tablet daily (multivitamin) Depakote 750mg one tablet twice a day (used to treat seizures) Docusate 100mg one tablet twice a day (used to treat/prevent constipation) Senna Lax 8.6mg two tablets daily (used to treat/prevent constipation) Duloxetine 30mg take three tablets daily (maybe used to treat depression) Ear Drops .5% place 5 drops per ear twice a day (used to treat/prevent ear infection or remove ear wax) Fexofenadine 180mg one tablet daily (used to treat hay fever and chronic skin hives and itching) Furosemide 40mg one tablet on Monday, Wednesday and Fridays (diuretic) Hydrochlorothiazide (HCTZ) 25mg one tablet daily (used to treat high blood pressure) Polyethlene Glycol 3350 Powder one capsule in 8-12 ounces of water (used daily for constipation) Review on 07/16/20 of client #1's April-July 7, 2020 MARs reflected the following: -Blanks at 7:00 AM: 07/06/20 for Cerovite Tablet, Depakote, Docusate and Senna Lax -Blanks at 8:00 AM: 07/06/20 for Duloxetine, Ear Drops, Fexofenadine, Furosemide, HCTZ and Polyethlene Glycol 3350 Powder	V 118		

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V 118	Continued From page 9 -Blanks at 12:00 Noon 04/30/20 & 05/15/20 for Atarax Review on 07/16/20 of the facility's General Event Report (GER) for client #1 dated 07/15/20 revealed: -Blanks on the 07/06/20 MAR for 7:00 and 7:30 AM were discovered as error on 07/06/20 at 9:30 AM During interview between 07/16/20 and 07/22/20, the QA/QI (Quality Assurance/Quality Improvement) Compliance Manager reported: -The GER was generated through the automated electronic medication system. The reported was completed for each home of the previous days' medication administration results -She reviewed and monitored the GERs daily for the agency. -The medication error for clients #1-#4 were discovered 07/07/20. The date of 07/06/20 documented on the GER by the Qualified Professional (QP) must have been an error when she typed in the information into the program. Of all the GERs printed for clients #1-#4, the 07/06/20 date only appeared on client #1's record. B. Review between 06/29/20 and 07/08/20 of client #2's record revealed: -Admitted 01/27/97 -Diagnoses of Profound IDD, Seizure Disorder and Myoclonic Hysarchthmia -Physician's orders dated 06/01/20 listed medications which included: Keppra 500 mg two tablets twice daily (used to treat seizures) Multivitamin one tablet daily Protonix 40 mg one tablet daily (used to treat certain stomach and esophagus problems)	V 118		

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Vitamin D3 1000 units (u) one tablet daily (fat soluble group that helps the absorption of calcium and phosphorus)

Review on 07/16/20 of client #2's April-July 7, 2020 MARs reflected the following:
-Blanks at 7:30 AM:
07/06/20 for Protonix
-Blanks at 8:00 AM:
07/06/20 for Keppra, Multivitamin and Vitamin D3

C. Review between 06/29/20 and 07/08/20 of client #3's record revealed:
-Admitted 01/27/97
-Diagnoses of Profound IDD and Seizure Disorder
-Physician's orders dated 06/01/20 listed medications which included:
Culturelle Capsule one tablet daily (Probiotic supplement used for digestive support)
Depakote 250mg four tablets twice daily
Neurontin 300 mg two tablets twice daily (used to treat seizure and nerve pain)
Keppra 500 mg two tablets twice daily
Marlissa 0.15-0.30 one tablet daily (used as an oral contraceptive)
Polyethlene Glycol 3350 Powder one capsule in 8-12 ounces of water
Tegretol XR 400 mg one tablet twice daily (anti-convulsion medication used to prevent and control seizures)
Vitamin B6 100 mg one tablet daily (water soluble that benefits the central nervous system)
Vitamin D3 1000u one tablet daily

Review on 07/16/20 of client #3's April-July 7, 2020 MARs reflected the following:
-Blanks at 7:00 AM:
07/06/20 for Depakote, Neurontin,

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V 118	Continued From page 11 Keppra, Marlissa, Tegretol and Vitamin B-6 -Blanks at 8:00 AM: 06/29/20 for Culturelle 07/06/20 for Culturelle, Polyethlene Glycol and Vitamin D3 D. Review between 06/29/20 and 07/08/20 of client #4's record revealed: -Admitted 07/17/97 -Diagnoses of severe IDD, Seizure disorder and Cerebral Palsy -Physician's orders dated 06/01/20 listed medications which included: ClearLax Powder (Polyethlene Glycol) mix 17 ounces in 8oz of beverage of choice three times a day with meals (used to treat constipation) Lamictal 200 mg one tablet twice a day (anti-epileptic medication used to treat seizures) Vitamin D3 1000 units one tablet daily Centrum Chewable one tablet daily Review on 07/16/20 of client #4's April-July 7, 2020 MARs reflected the following: -Blanks at 7:00 AM: 07/06/20 for Polyethlene Glycol and Vitamin D3 -Blanks at 8:00 AM: 07/06/20 for Lamictal and Centrum Chewable -Blanks at 12 Noon: 05/04/20, 05/12/20 & 07/06/20 for Polyethlene Glycol -Blanks at 5:00 PM: 05/04/20 for Polyethlene Glycol Review on 07/16/20 of the facility's internal "Medication Error incident" report dated 07/15/20 revealed the following: -"Incident Summary from QA/QI	V 118		

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V 118	Continued From page 12 Investigation: On 7/7/20, we run reports each day on missed medications as we use an electronic medication administration system [name of system] that tracks all medications for each of our locations. Administration alerted the directors on 7/7/20 that the system shows the 7am and 8am medications were not administered. All medications from 6am and 6:30am were administered and all other medications starting at 12pm were administered as directed. It was determined...medications were not administered due to miscommunication from the staff leaving off 3rd shift on July 6th..." -"By definition, a medication is not deemed as missed until the end of the day (11:59pm); therefore, we do not get official notification until the following day." -The report only listed medications missed by client #1. During interviews between 07/16/20 and 07/22/20, staff #5 and staff #7 reported the following about 07/06/20: -Both worked with each other between 10:45 PM and 7:00 AM, which was 3rd shift. -The third shift staff administered medication prescribed for 6:00 AM & 6:30 AM. Client #1 was the only client who had medications (Atarax & Synthorid) that needed to be administered during that time frame. Third shift would administer 1st shift medications scheduled for 7:00 AM and 8:00 AM if an oncoming shift did not have a staff trained to administer medications or if the oncoming staff requested third shift. Medications could be administered either one hour before or one hour after the assigned time. -Staff #8 administered only the 6:00 AM and 6:30 AM medications for client #1 on 07/06/20. -The regularly scheduled 1st shift staff had an emergency and did not come to work. At 7:00	V 118		

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AM, the QP showed up to cover the shift. Until 7:00 AM, neither were aware of the change in regular first shift staff.

-Until 07/07/20, neither were aware the QP had not been trained in "medication administration." The QP texted each of them on 07/07/20 to ask who administered the morning medications on 07/06/20. Both staff explained to the QP, first shift staff administered medications scheduled between 7:00 AM-3:00 PM.

The QP was unavailable for interview between July 16-24, 2020.

During interviews between 07/16/20 and 07/22/20, the QA/QI Compliance Manager reported:

-Staff have to be trained in both Medication Administration by the nurse and the specific Electronic Medication Administration System. When possible, both trainings were completed around the same time.

-The QP was not trained in the facility's Electronic Medication Administration System until 07/09/20. Outside of the regular QP duties, the QP had been providing coverage in the homes. Other group home staff would not have known the QP had not completed Electronic Medication Administration System training.

-She conducted an internal investigation regarding the 07/06/20 missed medications by clients #1-#4. On 07/06/20, the clients 12 noon meds were administered by another staff from a different home. The QP thought the 7:00-8:00 AM medications were administered by 3rd shift staff (#5, #7).

During interview on 07/21/20, the Clinical Nurse Manager reported the following regarding blanks on the MARs except on 07/06/20:

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V 118	Continued From page 14 -Either medication was missed or there was an issue with the Internet system at the home to allow documentation of medications administered. -She did not document when a problem with the Internet would have had connection issues. -04/15/20 12 Noon missed dosage of Atarax for client #1 was due to the on duty staff was not certified to administer medication -05/15/20 12 Noon missed dosage of Atarax for client #1, she could not locate an explanation why the MAR was blank -06/28/20 8:00 AM missed dosage of Cultrell for client #3, she could not locate documentation to explain why the MAR was blank During interview on 07/22/20, the trainer for the electronic Medication Administration Program at the Pharmacy reported the following: -The program was set to provide alerts within hours of missed dosages of medication -A dashboard feature allowed users to monitor and track during real time of percentages of how many meds had been administered for that location or system wide. -As part of her training, she encouraged users to establish systems to monitor and track the medication system several times a day. -She was not sure what system the management of the group home utilized to review and monitor the electronic Medication Administration program.	V 118		
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	V 290		

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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 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

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V 290	Continued From page 16 as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staffing was maintained to meet the needs of 4 of 4 clients (#1-#4). The findings are: Review between 06/29/20 and 07/08/20 of client #1's record revealed: -Admitted 01/27/97 -Diagnoses of Severe IDD (Intellectual Developmental Disability), Cerebral Palsy and Seizure Disorder -Treatment plan dated 11/01/19 noted she was non-verbal and exhibited behaviors (aggression /assaultive) when agitated. She utilized a behavior plan. -"Protective Device Order and Documentation of Use-Medical" form "instructions for use Hand mitts and Right elbow splint are to be used at all times, until the wound on her left arm is healed. During use, check every 30 minutes and remove for 10 minutes, if used for 1 hour, 59 minutes. Remove for meals and bathing. Do not use Right elbow splint at night. Use Posey mitts on both hands at night." Review between 06/29/20 and 07/08/20 of client #2's record revealed: -Admitted 01/27/97 -Diagnoses of Profound IDD, Seizure Disorder and Myoclonic Hysarchthmia -Treatment plan dated 02/01/20 noted he was non-verbal and behaviors included PICA. He required 24 hour supervision, "hands on assistance to accomplish most self-help and daily	V 290		

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living skills..." He followed a 2 hour toileting schedule and needed to be taken to the bathroom every 2 hours. Could pull up and down clothes, sit on toilet, flush toilet but would put hands in toilet and smear feces.

Review between 06/29/20 and 07/08/20 of client #3's record revealed:
-Admitted 01/27/97
-Diagnoses of Profound IDD and Seizure Disorder
-Treatment plan dated 07/01/19 non-verbal needs total assistance with bathing, dressing, toileting. She required "continuous supervision to assist with her behavior of elopement, hitting, self injurious behavior and minor property destruction."

Review between 06/29/20 and 07/08/20 of client #4's record revealed:
-Admitted 07/17/97
-Diagnoses of severe IDD, Seizure disorder and Cerebral Palsy
-Treatment plan dated 01/09/20 noted she was non-verbal, needed physical assistance to walk and "I require 24 hour supervision; do not leave me alone because I could fall...I require total assistance with all self help task including eating, bathing, dressing, grooming and taking a shower." She assisted with meal time but was mainly monitored and fed by staff to reduce risk of choking. 1:1 supervision was noted at the day program not at the group home.

Review on 07/08/20 of facility's work schedules between May 1-July 17, 2020 revealed:
-The facility managed the group home using three shifts (1st shift -7:00 AM-3:00 PM, 2nd shift-2:45 PM-10:30 PM, 3rd shift-10:15 PM-7:15 AM)

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V 290	Continued From page 18 -Two staff scheduled per shift except one staff scheduled as follows: May: 2nd, 9th, 10th (1st shift); 23rd (2nd shift); 7th, 31st (3rd shift); 8th, 15th (1st shift & 7:15 PM-10:15 PM); 3rd, 4th, 18th, 24th, 25th (1st & 2nd shift); 22nd (1st & 3rd shift); 11th, 12th, 14th, 19th, 20th, 21st, 26-30th (7:00 PM-10:15 PM); 16th (7:00 PM-10:15 PM & 3rd shift) June: 19th, 20th (2nd shift); 7th (3rd shift); 12th, 27th (1st & 3rd shift...7:00 PM-10:15 PM); 3rd, 5th, 9th, 10th, 14th, 16th, 17th, 23rd, 24th, 28th (7:00 PM-10:15 PM); 1st, 4th, 13th, 26th (7:00 PM-10:15 PM & 3rd shift); 6th, 11th (2nd & 3rd shift); 8th (2nd-no staff listed & 3rd shift one staff listed) July: 3rd, 5th, 6th, (1st shift); 15th-17th (3rd shift); 11th (1st, 2nd & 3rd shift); 12th, 13th (1st & 2nd shift) During interview on 06/20/20 at 9:50 AM, staff #1 reported: -She was the only staff on duty. -Staff #2 was scheduled to come into work at 10:00 AM and worked a split shift.	V 290		

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V 290	Continued From page 19 During interviews between 06/29/20 and 07/07/20, four of four paraprofessional staff reported the following: -Normally two staff worked at the home on each shift. Recently, all noted more than two occasions within the past three months in which they worked alone. Staff coverage issues on second shift, call outs and reassignment to another home were reasons for only staff on duty at this home. -It was difficult to monitor all four clients, conduct daily routine (toileting, meals, cleaning) and serve as the only staff at the home. -Staff reiterated client needs identified in the treatment plan. Three staff thought client #4's treatment plan noted she required 1:1 assistance. -Client #4 became agitated by peers making noises. -Client #3 pulled client #4's hair, therefore, the two could not be left alone in the same area. -Client #2 would put his finger in small holes. An example included the bathroom sink had a hole that prevented overflow of water. He would put his finger inside the hole. -Client #1 had a behavior plan that included protective devices a mitten and arm brace. During interview on 07/01/20, client #4's care coordinator reported: -Prior to March 2020, she had conducted onsite announced visits to the group home. Two staff were always on duty. -If one staff was on duty, she would have concern as "it would be a lot" for one person to monitor all four clients at the same time. During interview on 06/30/20, co-guardian #2 for client #1 reported: -He was concerned about staff and clients at the home for occasions with one staff on duty. He	V 290		

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V 290	Continued From page 20 provided a scenario that all clients at the home were non verbal, limited to no independent self help skills what would happen to both clients and staff if that on duty staff had a medical emergency? During interview on 06/30/20, the House Supervisor reported the following: -Although the state regulation for staffing ratio was 1:4, the agency liked to have 2 staff on duty. - She thought two staff were provided on each shift was for the comfort level of the clients' parents. During interview on 06/30/20, the Qualified Professional reported the following: -The agency made sure two staff were on each shift. -She was not aware of occasions one staff was on duty. -Management provided fill-coverage if needed for the home During interview on 07/08/20, the Quality Assurance/Quality Improvement Compliance Manager reported: -The staff/client ratio was 1:4. The agency tried to have two staff on duty for best practices. One staff could meet the needs of four clients in the home. - Besides bathing/dressing, the clients required little assistance. -None of the staff had noted concerns to the agency regarding staffing patterns to the group home. This deficiency was cited 2 times on 04/26/18 and 04/09/19.	V 290		

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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 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 4 clients (#1). The	V 291		

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findings are:

Review on 06/30/20 of client #1's record revealed:
- Admission date 01/15/97
- Diagnoses included Severe Intellectual and Developmental Disabilities (IDD), Cerebral Palsy and Seizure Disorder
- The parents served as co-guardians and both needed to be contacted for concerns in regards to care and services
- Treatment plan dated 11/01/19 with a crisis plan section:
  -"What a crisis looks like for me? A crisis would be not having her medication, if she had a medical emergency, and/or did not have necessary 24 hour supervision."
  - "...Who to call: In the event of a medical emergency, seek medical attention immediately. [Client#1]'s parents should be contacted [contact information listed]..." Additional notation indicated the following should be contacted and their contact information: Facility Qualified Professional (QP), Day Program Manager, Local Management Entity Care Navigator, Facility Social Worker and Facility House Supervisor should be contacted.

Review on 06/30/20 of a level one incident report dated 05/12/20-05/18/20 revealed the following:
-Report dated 05/12/20 at 1:40 PM by staff #5 & #6: On 05/10/20 at 3:30 AM, staff #6 went to put covers in the washer machine while client #1 was on the toilet. When staff #6 returned she observed client #1 "digging in her arm." Staff #6 immediately "tended to" client #1's arm. The arm was cleaned off and bandage replaced. Staff #6 immediately took a picture and called the House Supervisor "who she thought was on call contact person. [Staff #6] was directed to call Qualified

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Professional."

-Report updated 05/18/20 at 3:19 PM by the facility's Quality Assurance/Quality Improvement (QA/QI) Compliance Manager: Staff #6 went into client #1's bedroom and discovered she was soiled. She removed the bedding and placed client #1 into the bathroom and removed her soiled clothing and protective mittens on her hands. Staff #6 placed client #1 on the toilet to ensure she didn't have to go to the bathroom. Staff #6 took the soiled clothing and bedding to the washing machine. During this time, client #1 was able to access her wound and scratched her arm. Staff #6 contacted the on-call supervisor, House Supervisor. The House Supervisor requested a picture to determine if the wound required immediate medical attention. House Supervisor determined that immediate medical attention was not needed and the wound care nurse would be there on Monday and could assess the bandage and wound at that time. House Supervisor instructed staff #6 to contact the QP. Staff #6 was not able to reach her on the phone but left a detailed voicemail about the incident. Staff #6 placed protective arm coverings back on client #1's arm and her protective mittens with fresh clothing. Client #1 was returned to bed by staff #6.

Examples the facility failed to coordinate with specialized medical professionals, within their agency's internal system of care and guardians for client #1 regarding the 05/10/20 incident:

A. Review on 07/01/20 of client #1's Home Health Care Nurse's notes between April 10, 2020-June 8, 2020 obtained from the Home Health agency revealed the following:

-Wound care services started 07/09/19

-Services were provided 2-3 times per week

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V 291	Continued From page 24 -Contact information for the Home Health Care entity was provided During interview on 07/02/20 the Home Health Care Nurse reported the following: -On 05/11/20, she provided wound care as client #1 had reopened her wound. No infection was noted and the bandage had been replaced per protocol by group home staff. The wound was bigger in size, therefore a couple of layers of skin had been impacted. -Prior to her regularly scheduled visit on 05/11/20, neither her nor the home health agency were notified of client #1's wound reopening on 05/10/20 -Her agency utilized an on-call administrator/nurse on the weekend to take calls. If the home health agency would have been contacted, the on-call administrator/nurse would have made a decision if immediate medical treatment was needed based on assessment information and made her aware of the incident prior to the next scheduled visit. -She was not aware of the facility's specific notification of incident processes. She was aware the facility had nurses on staff. Although the facility's nurse was not a primary care provider for the wound, a trained/credentialed nurse would have been able to medically assess the wound to determine if immediate treatment was warranted. During interview on 07/02/20, the House Supervisor reported: -She did not call any nurses. The home health nurse was coming out every Monday, Wednesday and Friday. The Protocol for calling the facility's on-call nurse was if bleeding was observed, contact the nurse at the center. The client could be taken to the center. If during the week, call the nurse. On the weekend, if not	V 291		

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bleeding, then they should just rewrapped it.
-She indicated this procedure was not in writing but was implemented by the previous Nurse Director in 2019. The facility was currently without a Nurse Director.
-The QP would be responsible for contacting the Guardians as well as nurses to determine if medical treatment was needed.

B. During interview on 07/01/20, the Residential/Community Services Director reported the following:
-In cases of weekend and after hour emergencies, the facility utilized an administrator on-call system. The on-call system was compiled of administrators such as Nurses, Qualified Professionals and House Supervisors. On-call status rotated after 7 days. The role of the on-call person was to follow up with the the facility's professionals responsible for the affected client or staffing concern.

During interview on 06/30/20, staff #6 reported the following regarding 05/10/20:
-She called the on-call administrator, who also was the facility's House Supervisor. She was not sure of an exact time she called.
-The House Supervisor told her to call the Qualified Professional (QP). The QP did not answer so she left a message.
-She called the House Supervisor again to provide an update on the phone call. The House Supervisor advised staff #6 to take a picture of client #1's reopened wound on the left arm and send it to her.

During interview on 06/30/20, the House Supervisor reported the following:
-Previously, she served as the staff who contacted guardians. Since February 2020, the

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task of coordination with the families had been assigned to the QP.

-On 05/10/20, staff #6 contacted her around 7:00 AM regarding client #1 had reopened her wound overnight. She did not recall the exact time of the incident.

-She instructed staff #6 to call the QP, complete an incident report and take a photograph of the wound. The Home Health Care Nurse was pre-scheduled to come out the next day. "It wasn't that bad, just the top of the wound was already open and she got into the top section of it...The top skin had just come off."

During interview on 06/30/20, the QP reported the following regarding the 05/10/20 incident:

-"We contacted the nurse who was coming in for the wound care. We called her, I don't know when she was called. I was not there when that (Home Health Care) nurse came out. She would call me to verify that time to come in. She had different nurses. I don't know the name of the company they were using for home health services for her."

-She did not contact a nurse from Home Health Care nor did she know who contacted a nursing professional.

C. Review on 07/07/20 of the facility's "Notification to Parent-Guardian" policy indicated the department head shall be responsible for ensuring that parents/legal guardians received notification in the event of unusual occurrences regarding their son/daughter. The policy listed where the documentation of the contact should be noted but no clarification regarding time frames to notify guardians.

Review on 06/30/20 of the incident report dated 05/18/20 completed by the QA/QI Compliance

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 _____	C 07/24/2020

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 291	Continued From page 27 Manager revealed the following regarding notifications: -05/10/20 at 7:00 AM to the House Supervisor -05/10/20 at 7:30 AM to the QP -05/11/20 at 9:00 AM notification to the mother (co-guardian #1) -05/11/20 at 9:55 AM notification to the father (co-guardian #2) During interview on 06/30/20, client#1's guardians reported: -Co guardian #1: verified she was notified of the 05/10/20 the following morning. Usually, she was notified immediately of occurrences with her daughter. The facility hired a new QP. This oversight of guardian notification was an isolated incident. -Co guardian #2: was also informed on 05/11/20 by the QP. He felt the facility was not transparent in sharing information with him. He was presented the 05/10/20 incident as if it had just occurred the morning of 05/11/20. He considered the event of 05/10/20 as a medical emergency and felt he should have been notified sooner than 30 hours after the incident. He noted his daughter did not receive any type of clinical assessment regarding the wound until 5/11/20. During interview on 06/30/20, the QP reported the following: -On Sunday 05/10/20, she informed her boss (Residential/Community Services Director) of the incident. -On Sunday 05/10/20, she was trying to resolve a personal matter and was not able to contact client #1's guardian. She called the parents on Monday 05/11/20. -"We have 12 hours that we can call them. That's always been the policy." She followed up with the Residential/Community Services Director	V 291		

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V 291	Continued From page 28	V 291		

and he reminded her of the time frame.

During interviews between 06/29/20 and 07/08/20, QA/QI Compliance Manager reported the following regarding client #1's incident on 05/10/20 in which her wound was reopened:

-One of client #1's co-guardians had expressed concerns regarding her care as well as being notified of incidents that had occurred.

-They did not notify on-call nurse for the facility or the on-call nurse for the home health agency.

During interviews between 06/29/20 and 07/08/20, the Residential/Community Service Director and the QA/QI Compliance Manager revealed both:

-Felt the facility was in compliance with reporting the incident to guardians and other professionals as this incident met level one reporting requirements which only required quarterly.

-Thought the facility had between 12-72 hours to notify persons inclusive of the guardian of the incident.

Review on 07/10/20 of the facility's Plan of Protection dated 07/10/20 submitted by the facility's QA/QI Compliance Manager revealed the following:

-"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?

1. We will be notifying the care coordinator for a meeting to discuss the crisis plan of the ISP (Individual Support Plan). We will ask that clarification be given on what is an emergency for each resident and what is the definition of medical emergency. We will define when (immediately, 24 hours, 48 hours, etc.) the

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V 291	Continued From page 29	V 291		

parents/guardians, care coordinators and other professionals involved in the resident's treatment will be contacted following an incident.

2. There is a scheduled behavior review plan meeting with the care coordinator and parents/guardians for July 31, 2020 at 9am. We will ensure that during this meeting it confirmed the preferred method of communication and frequency with the parents/guardians.

3. TLC (Licensee) will be reviewing its on-call procedures to clearly define the duties and responsibilities to ensure staff are clear. we have reviewed the policy with all staff during meeting held on July 9th at 9am.

-Describe your plans to make sure the above happens.

1. Once the clarification on medical emergency and contact preferences are confirmed, we will alert the staff of the home. We will post in the home, reminders on how to communicate and report incidents with the parents/guardians.

2. We will meet with all staff to ensure that they understand incident reporting policy and procedures (completed on July 9th). All staff will be reminded who to contact if someone is unavailable. This includes calling our nurse on call for guidance if qualified professional or director of residential services is unavailable.

3. We have clarified with staff who is the point of contact with all parents/guardians. If staff are unable to reach the Qualified professional/house manager, they have been instructed to reach, Residential Services director."

Since August 2019, client #1 had a history of self injurious behavior in which she would reopen her wound. On 05/10/20, client #1 reopened her wound at 3:30 AM. Prior to the incident, she received specialized wound care through home

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V 291	Continued From page 30 health nurse three times a week. Per her treatment plan, both guardians & care management should be notified of medical emergencies. The facility's internal on call procedures required management level staff to communicate amongst themselves of occurrences at the group homes. The lack of communication on 05/10/20 by the facility with client #1's specialized wound care nurses, notification of guardians and internal on call processes, did not allow a collaborative effort for all to make decisions regarding client's wound being reopened. This practice of lack of service coordination is detrimental to client #1's health, safety and welfare. This impacted other agencies' qualified professionals ability to allow and provide input regarding medical treatment to meet her needs. This 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. This deficiency was cited 2 times on 08/29/17 and 04/09/19.	V 291		