STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G029	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEANNE GROUP HOME	900 ROSEANNE DR KINSTON, NC 28504

(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) COMPLETION DATE
{E 022}	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop policy and procedures for sheltering in place in their Emergency Plan (EP). This had the potential to affect all clients (#1, #2, #3 and #4). The finding is:	{E 022}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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{E 022}	Continued From page 1 Review on 11/16/21 of the facility's revised EP dated 9/13/21 did not include language for situations that would call for the clients and staff to shelter in place. During an interview on 11/16/21 with the facility's corporate representative revealed that the lockdown policy would provide the same instructions for staff who needed to shelter in place. The corporate representative acknowledged the facility did not develop a specific shelter in place policy which might encompass different risky situations and how to respond.	{E 022}		
W 000	INITIAL COMMENTS A revisit was conducted on 11/16/2021 for all previous deficiencies cited on 8/24/21. The following deficiencies have been corrected; E0025, W263, W441 and W460. The facility remained out of compliance in E0022 and W125.	W 000		
{W 125}	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to continually seek a legally sanctioned decision maker for 1 of 3 audit clients (#4) needing representation. The finding is: Record review on 11/16/21 of Client #4's medical chart contained a letter, dated 9/7/21 addressed	{W 125}		

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{W 125}	Continued From page 2 to Lenoir County Department of Social Services (DSS) by the qualified intellectual disabilities professional (QIDP) requesting an assessment for guardianship. There was no other documentation in the chart on actions taken or follow up services needed to obtain guardianship. Interview on 11/16/21 with the home manager revealed that Client #4 had started to refuse two of his medications because he complained of lacking control of his bowel and bladder. The nurse was made aware of these concerns and met with Client #4 to discuss the benefits of taking the medications. Interview on 11/16/21 with Client #4 revealed that he refused the medications because he had incontinence accidents in public. He had not decided to resume taking the medications. Client #4 mentioned that he had not selected a guardian because he did not have any family besides a cousin and he had not seen his cousin in a "blue moon." Client #4 acknowledged that he did not appoint a power of attorney (POA), and had not verbalize with the facility any decisions affecting life ending situations. Interview on 11/16/21 with the Registered Nurse (RN) revealed that she had recently spoken to Client #4 about the importance of taking all of his prescribed medications especially since he has developed chronic kidney disease. The RN was able to discuss with the doctor about discontinuing a medication that caused bowel incontinence but stressed that it was important for Client #4 to resume taking medication for urinary retention. The RN was advocating for Client #4 to have legal representation for health decisions.	{W 125}		

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{W 125}	Continued From page 3 Interview on 11/16/21 with the Qualified Intellectual Disabilities Professional (QIDP), admitted that he unknowlingly filed the guardianship papers with the wrong Department of Social Services (DSS). Instead of contacting the the local agency in Lenoir County, he should have filed in the county of origin where Client #4 lived before placement. The QIDP stated that he would follow up with Greene County DSS to proceed with guardianship efforts.	{W 125}		