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 _____	08/24/2021

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 staff interview and the review of the facility's Emergency Preparedness Manual (EP), the facility failed to develop policy and procedures for sheltering in place in their EP. This had the potential to affect all clients (#1, #2, #3 and #4). The finding is:	E 022	Revision to the emergency preparedness plan (Disaster Plan) will be completed to include shelter in place procedures. Staff will be in-serviced on updated plan by QP. QP and GHM will monitor annually. DHSR - Mental Health SEP 08 2021 Lic. & Cert. Section	10/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sarah T. Howell | TITLE: QC Member | (X6) DATE: 9-3-2021

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 8/24/21 of the facility's EP dated 2021 did not include language for situations that would call for the clients and staff to shelter in place. During an interview on 8/24/21 with the Qualified Intellectual Disabilities Professional (QIDP), he revealed that the policy addressed how to respond to a lockdown but did not find a policy on how to shelter in place.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025	Revision to the emergency preparedness plan (Disaster Plan) will be completed that will include a listing of accommodations or agreements for housing for emergency purposes. Staff will be in-serviced on updated plan by QP. QP and/or GHM will monitor annually.	10/24/21

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E 025	Continued From page 2 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Manual (EP), the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients (#1, #2, #3 and #4) in the home. The findings is: Review on 8/24/21 of the facility's 2021 EP revealed there was no listing of accommodations or agreements for housing for emergency purposes. During an interview on 8/24/21 with the Qualified Intellectual Disabilities Professional (QIDP), he stated the facility would most likely send the clients to one of their group homes or the vocational center. The QIDP acknowledged that the EP did not list any specific location as an option to relocate clients.	E 025		

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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 staff interviews, the facility failed to ensure 1 of 4 audit clients (#4) had the right to a legally sanctioned decision maker. The finding is: Review of client #4's Individual Program Plan (IPP) dated 10/22/20, revealed that he was admitted to the facility on 11/6/84, his mother was deceased and he did not have a legal guardian. He functioned in the moderate range of intellectual functioning and took Alprazolam, an anti-anxiety medication, used to treat his tremors. During his last IPP review, no family members participated in the plan. The IPP revealed he had experienced some significant health issues over the year. On 5/19/20, client #4 was diagnosed with pneumonia (left lower lung) and on 5/23/20 diagnosed with COVID-19 that required hospitalization until 6/8/20. A further review of the plan noted that client #6 "does not seem to understand scope of Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, corporate policies as it relates to employees visiting him, infection control (gloves use)." During an interview on 8/24/21 with the Registered Nurse (RN) revealed that she had questioned unnamed staff, why client #6 did not have a legal guardian, given his history of	W 125	QP will contact DSS and clerk of court stating our concerns of medical and financial decision making for guidance on full or limited guardianship as it relates to medical and montary decisions	9/17/21

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W 125	Continued From page 4 refusing some services. She indicated that client #6 had expressed to her that he did not need a guardian, because he was not crazy. During an interview on 8/24/21 with the Qualified Intellectual Disabilities Professional (QIDP), who recently transferred to the facility, revealed he has known client #6 a long time and have not known him to have a legal guardian. The QIDP acknowledged that it was not common for clients served in facilities to not have a legal guardian appointed.	W 125		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that they had consent from 1 of 4 audit clients (#4) who represented himself, as guardian. The finding is: Review of client #4's Individual Program Plan (IPP) dated 10/22/20, revealed that he did not have a legal guardian. He functioned in the moderate range of intellectual functioning and took Alprazolam, an anti-anxiety medication, used to treat his tremors. The record indicated that on 8/17/20, he signed a consent to allow restrictive interventions by the facility. The consent expired on 8/17/21. During an interview on 8/24/21 with the Qualified	W 263	QP will have consent forms signed and will monitor annually to ensure compliance with standards.	9/3/21

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W 263	Continued From page 5 Intellectual Disabilities Professional (QIDP), he revealed that he was assigned to the home last month and was responsible for ensuring that consents were signed and current. The QIDP acknowledged that he was not aware that client #4's restrictive intervention's consent expired last week.	W 263		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (client's #1, #2, #3 and #4). The finding is: Review on 8/23/2021 of facility fire drill reports for August 2020-July 2021 revealed third shift drills were conducted at 6:37am, 6:27am, 6:25am, 6:15am, 6:15am, 6:18am, 6:55am, 6:45am, 11:00pm, 6:05am, 11:17pm and 11:38pm. The fire drills were not conducted during deep sleeping hours between 1am and 4am on third shift. Interview on 8/24/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the house manager is responsible for the date and time of fire drills and acknowledged the fire drills should be varied throughout the shift.	W 441	Random times will be applied to fire drills to ensure that the timing is not repetitive. QP and GHM will review monthly.	10/24/21
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

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W 460	Continued From page 6 Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure dietary orders for modified diets for 2 of 4 audit clients (#2 and #3) were followed as written. The findings are: A. During observations in the home on 8/24/21 at 6:50am, client #2 was observed eating breakfast. Client #2's meal consisted of unmodified instant oatmeal with apples, unmodified strawberry yogurt with fruit particles and finely chopped toast. Client #2 consumed 100% of the oatmeal with no issue but did not eat any toast or yogurt. Review on 8/23/21 of client #2's Nutritional Evaluation dated 4/5/21 revealed a diet order of pureed consistency. During an interview on 8/24/21 with Staff A, she stated that she prepared breakfast for client #3 but did not blend it to pureed texture. Staff A offered no explanation for the reason the food was not modified for breakfast, when it was modified during other meals that she prepared for client #3. During an interview on 8/24/21 with the Home Manager (HM) she commented that client #2's toast looked dry and that liquid was not added. During an interview on 8/24/21 with the Qualified Intellectual Disabilities Professional (QIDP), he acknowledged that client #3's diet order was to	W 460	Staff will be in-serviced by QP on each individuals diet plan to ensure compliance. QP and/or GHM will observe periodically and will document in monthly notes. Client #3- QP will contact OT and PT to discuss a re-evaluation to determine if clients preferences may be accommendated. The current diet will be followed until any changes are made by OT and/or PT.	10/24/21

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W 460	Continued From page 7 prepare food pureed. B. During observations in the home on 8/24/21 at 6:45 AM, Client #3 was served oatmeal, strawberry yogurt and a whole slice of toast. Client #3 ate the toast; holding the slice to his mouth and biting off pieces. Client #3 did not display any swallowing complications. Review on 8/24/21 of Client #3's Nutritional Evaluation dated 1/4/21 revealed that his food should be chopped into 1/2 inch pieces. It further revealed that recent modified barium swallow studies that he had chewing and swallowing concerns. He should be monitored for safe PO (by mouth) intake. During an interview on 8/24/21 with Staff A revealed that she prepared his meal and did not chop the toast because client #3 did not like it cut up. Staff A indicated that the order required chopping his food because when client #3 put food in his mouth, he did not chew it, just swallowed it. During an interview on 8/24/21 with the QIDP, he acknowledged that the diet orders were for chopped 1/2 inch pieces. The QIDP stated that if client #3 had a preference to eat his toast whole, that the facility could discuss if modifications were permitted and make changes to the diet if necessary.	W 460		