					0					
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						MB NO. 0938-0391 (X3) DATE SURVEY				
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		COMF	PLETED			
		34G029	B. WING _			(10/1	C 13/2022			
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	-				
ROSEAN	INE GROUP HOME		900 ROSEANNE DR KINSTON, NC 28504							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		J	(X5)			
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		CTION SHOULD	BE	COMPLETION DATE			
W 000	INITIAL COMMENT	ſS	W OC	00						
W 154	A complaint survey 10-13-2022 for intal Deficiencies were of STAFF TREATMEN CFR(s): 483.420(d)	ited. IT OF CLIENTS	W 15	54						
	violations are thorou This STANDARD is Based on record re facility failed to thor unknown origin for finding is: Review on 10/13/22 investigations revea #1 had been initiate identified on 10/4/22 Review on 10/13/22 incident reports for facility for the time p October revealed a completed on 9/24/	s not met as evidenced by: eviews and interviews, the oughly investigate an injury of 1 of 1 audit clients (#1). The 2 of the facility's internal aled no investigation for client ed since the injury was 2. 2 of the facility's internal all clients residing in the period of September through n incident report was 22 at 8:00am for client #1								
	stomach. There wa 10/4/22 at 12:00pm check discoloration	ail and scratches on his s also an incident report dated regarding during a body to client #1's middle chest and the home manager (HM)								
	completed the incid check where she no purple as well as th A revealed she was	22 with Staff A revealed she lent report following a body oticed client #1's left side was e mid chest/breast area. Staff the one who completed client e day prior on 10/3/22 and the								

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEDADTMENT OF HEALTH AND HUMAN SEDVICES

TITLE

(X6) DATE

PRINTED: 11/08/2022

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/08/2022 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED						
		34G029	B. WING_			C 10/13/2022				
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE					
ROSEAN	NE GROUP HOME		900 ROSEANNE DR KINSTON, NC 28504							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 154	discoloration was no notified the HM and a chest Xray immed Interview on 10/13/2 was notified by Staf body check and not revealed she had sy the day of 10/3/22 a obtained written sta one staff that worke Interview on 10/13/2 Intellectual Disabiliti revealed that he be approximately 10/5/ was unable to comp the client being disc 10/5/22 and the fac records from the ho COVID-19 Vaccinat CFR(s): 483.430(f)(§ 483.430 Condition staffing. (f) Standard: COVIE staff. The facility m policies and proced fully vaccinated for this section, staff ar if it has been 2 wee completed a primar COVID-19. The con	ot visible. Staff A immediately I the facility physician ordered diately. 22 with the HM revealed she ff A immediately following the tified the physician. HM poken with staff that worked and 10/4/22 but had not tements from anyone except ed third shift on 10/3/22. 22 with the Qualified ies Professional (QIDP) gan an investigation on /22. The QIDP revealed he olete the investigation due to charged from the facility on ilty not being able to obtain ospital. tion of Facility Staff (1)-(3)(i)-(x) n of Participation: Facility ust develop and implement ures to ensure that all staff are COVID-19. For purposes of re considered fully vaccinated ks or more since they y vaccination of a primary	W 1		DEFICIENCY)					
	as the administratio the administration o multi-dose vaccine.	or COVID-19 is defined here on of a single-dose vaccine, or of all required doses of a clinical responsibility or client								

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/08/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` ´		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G029	B. WING	i		C 10/13/2022	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEAN	NE GROUP HOME				900 ROSEANNE DR KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 508	contact, the policies to the following facil care, treatment, or and/or its clients: (i) Facility employee (ii) Licensed practiti (iii) Students, traine (iv) Individuals who other services for th under contract or by (2) The policies and do not apply to the f (i) Staff who exclusi telemedicine service and who do not hav clients and other sta of this section; and (ii) Staff who provid facility that are perfet the facility setting an contact with clients paragraph (f)(1) of t (3) The policies and a minimum, the follow (i) A process for ensi- paragraph (f)(1) of t staff who have pend- been granted, exem- requirements of this whom COVID-19 va delayed, as recomm clinical precautions received, at a minim vaccine, or the first vaccination series for vaccine prior to staff	and procedures must apply ity staff, who provide any other services for the facility es; oners; es, and volunteers; and provide care, treatment, or ie facility and/or its clients, other arrangement. d procedures of this section following facility staff: vely provide telehealth or es outside of the facility setting e any direct contact with aff specified in paragraph (f)(1) le support services for the ormed exclusively outside of nd who do not have any direct and other staff specified in his section. d procedures must include, at owing components: suring all staff specified in his section (except for those ding requests for, or who have options to the vaccination a section, or those staff for accination must be temporarily nended by the CDC, due to and considerations) have num, a single-dose COVID-19	W 4	508			

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		AND HUMAN SERVICES				FORM	11/08/2022 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED			
		34G029	B. WING	;		(10/1) 13/2022			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
ROSEAN	INE GROUP HOME		900 ROSEANNE DR KINSTON, NC 28504							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 508	 (iii) A process for e additional precautio transmission and sp who are not fully var (iv) A process for tradocumenting the CO all staff specified in section; (v) A process for tradocumenting the CO any staff who have a secommended b (vi) A process by whe exemption from the requirements based (vii) A process for tradocumenting inform who have requested has granted, an exection; (viii) A process for tradocumenting inform who have requested has granted, an exection; (viii) A process for tradocumenting inform who have requested has granted, an exection; (viii) A process for tradocumentation, whi clinical contraindica and which supports exemptions from variand dated by a licer the individual reque is acting within their as defined by, and i applicable State and ensuring that such of (A) All informations sauthorized COVID-formations; a (B) A statement by formation and based for the individual formation and the recognized contraindication; and (B) A statement by formation and the statement by formatio	ensuring the implementation of ons, intended to mitigate the pread of COVID-19, for all staff locinated for COVID-19; acking and securely OVID-19 vaccination status of paragraph (f)(1) of this acking and securely OVID-19 vaccination status of obtained any booster doses by the CDC; hich staff may request an e staff COVID-19 vaccination d on an applicable Federal law; racking and securely nation provided by those staff d, and for whom the facility emption from the staff tion requirements; ensuring that all ich confirms recognized ations to COVID-19 vaccines is staff requests for medical accination, has been signed nsed practitioner, who is not esting the exemption, and who r respective scope of practice in accordance with, all d local laws, and for further documentation contains: specifying which of the 19 vaccines are clinically the staff member to receive clinical reasons for the	W 5	508						

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		AND HUMAN SERVICES				FORM	11/08/2022 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		34G029	B. WING				_ 13/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEANNE GROUP HOME					00 ROSEANNE DR KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 508	exempted from the vaccination required recognized clinical (ix) A process for en- secure documentat staff for whom COV temporarily delayed CDC, due to clinical considerations, incl- individuals with acu COVID-19, and indi- monoclonal antibod for COVID-19 treats (x) Contingency pla- vaccinated for COV Effective 60 Days A (ii) A process for en- paragraph (f)(1) of the vaccinated for COV who have been gra- vaccination required staff for whom COV temporarily delayed CDC, due to clinical considerations; This STANDARD is Based on record re- failed to develop po- include a process for delays with obtaining and contingency pla- vaccinated for COV Review on 10/13/22 Outbreak policy (da- contingency plan for	facility's COVID-19 ments for staff based on the contraindications; nsuring the tracking and tion of the vaccination status of /ID-19 vaccination must be d, as recommended by the l precautions and uding, but not limited to, the illness secondary to ividuals who received dies or convalescent plasma ment; and uns for staff who are not fully /ID-19. After Publication: usuring that all staff specified in this section are fully /ID-19, except for those staff nted exemptions to the ments of this section, or those /ID-19 vaccination must be d, as recommended by the l precautions and s not met as evidenced by: eview and interview, the facility plicies and procedures which or tracking staff with temporary the tracking staff with temporary of their COVID-19 vaccination ans for staff who are not fully /ID-19. The findings are: 2 of the facility's Pandemic ated 7/2/21) did not include a or new hires, staff that are not I not get vaccinated and do	W E	508			

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		AND HUMAN SERVICES				FORM	11/08/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		34G029	B. WING	i			_ 13/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEAN	INE GROUP HOME				00 ROSEANNE DR KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 508	Continued From pa	age 5	W t	508			
	confirmed the facili	22 with the program director ty had not written a policy 9 vaccination policy following staff vaccinations.					

Facility ID: 942503

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