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 04/11/2024

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
W 000	INITIAL COMMENTS A revisit was conducted on 4/11/24 for all previous deficiencies cited on 12/19/23. All deficiencies were not corrected and no new non-compliance was found. The facility is not in compliance with all regulations surveyed.	W 000		
{W 221}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an auditory examination for 1 of 3 audit clients (#2). The finding is: Review on 12/18/23 of client #2's record revealed she had not received an auditory examination. Further review revealed client #2 was admitted to the facility on 1/11/23. During an interview on 12/19/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 had not received her auditory examination. A follow up visit was conducted on 4/11/24: During an interview on 4/11/24, the QIDP stated he believes client #2's auditory examination was conducted. Further interview revealed the paperwork could not be located in client #2's chart.	{W 221}		
{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	{W 263}		

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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{W 263}	Continued From page 1 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 interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#2). The finding is: Review on 12/18/23 of client #2's Behavior Support Plan (BSP) implemented 2/6/23 revealed there was no signed consent by her legal guardian. During an interview on 12/19/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2's does not have a signed consent by her legal guardian. During an interview on 4/12/24, the QIDP stated he witnessed when client #2's guardian signed her BSP consent. Further interview revealed the consent could not be located in client #3's chart.	{W 263}		