PRINTED: 07/30/2018 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		MHL0411151	B. WING		07/1	9/2018			
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0171	0/2010			
ніскѕ н	HICKS HOUSE OF CARE  2611 ZOLA DRIVE GREENSBORO, NC 27405								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
V 000	INITIAL COMMENTS		V 000						
	The complaint was	y was completed on 7-19-18. substantiated (intake deficiency was cited.							
	category:	sed for the following service 'G .5600C: Supervised Living y Disabled Adults							
V 115	27G .0208 Client S	ervices	V 115						
	10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.								

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL0411151	B. WING		07/1	9/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
HICKS HOUSE OF CARE 2611 ZOL			A DRIVE BORO, NC 2	7405				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLET			
V 115	Continued From pa	ge 1	V 115					
	staff failed to assure	and record review, the facility e that space and supervision sure the safety and welfare of						
	revealed: - admission dat - he was 29 yea - he was diagno - Schizoaffe	ars old						
	reports revealed:	of the facility 's incident epartment was called by a lived approximately one block lying in the neighbor 's yard r transported client #1 to a of the event, former staff #1 ed by the Director/Qualified ).						
	department for all rerevealed:	7-19-18 of the local police ecords from 4-1-18 to 7-19-18						

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police on 7-8-18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411151	B. WING		07/1	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HICKS H	OUSE OF CARE	2611 ZOL GREENSE	A DRIVE BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 115	Continued From page 2		V 115			
	- he had an ups 18 - he was in the 12 minutes - after leaving t "cleaning up glass a was upset	8 with FS1 revealed: set stomach on Sunday, 7-8-bathroom approximately 10 - he bathroom, he began, and stuff," from when client #1 ed off while I was in the				
	guardian revealed: - she sees clier per month - client #1 has a - walking o - self-injurio					
	Coordinator reveals - a waiver has l additional staffing for client #1 has l	peen applied for to provide				
	- client #1 walk staff staying near - client #1 walk calm himself	8 with the D/QP revealed: s in the neighborhood with s in order to self-soothe and es down in someone 's yard				

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STATE FORM SSH411 If continuation sheet 3 of 4

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MHL0411151  B. WING 07/19/20  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE	2018
2611 ZOLA DRIVE	
HICKS HOUSE OF CARE GREENSBORO, NC 27405	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 115 Continued From page 3 - often claims he 's hurt, sick or has been assaulted - when client #1 went for a walk on 7-8-18, FS1 didn't do his job - it was FS1's second day on the job - FS1 was terminated that day - in the future, "We' il continue to try and work with [client #1] and monitor him in and out of the facility closely, to meet his needs."	

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