STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411122	A. BUILDING: _____ B. WING _____	02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY GROUP HOME	5709 CRANBERRY COURT GREENSBORO, NC 27405

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 2/27/2019. The complaint was substantiated (intake #NC148614). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or	V 291		

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V 291	Continued From page 1 safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure care coordination was maintained between the facility and other qualified professionals affecting 1 of 3 clients (#2). The findings are: Review on 2/22/2019 of client #2's record revealed: - Admission date: 8/4/2016; - Diagnoses: Autism Spectrum Disorder; Moderate Intellectual Disabilities; - A "Risk/Support Needs Assessment" updated on 6/15/2018: behaviors are episodic and quick. He will lash out and then retreat. He does engage in self-abusive behaviors and will bite himself until he bleeds. - No documentation was present indicating dates or topics of contacts that facility staff made with client #2's School; - Client #2 was non-verbal; - No documentation of client #2 having been picked up at school by facility staff rather than riding the school bus on 2/12/2019. Review on 2/25/2019 of the facility's incident reports revealed: - No incident reports related to client #2 having been picked up from school on 2/12/2019 due to behavioral issues. Interview attempts with client #2's Guardian on 2/26/2019 and 2/27/2019 were unsuccessful due to no response to messages requesting the Guardian call the Surveyor back.	V 291		

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V 291	Continued From page 2 Interview on 2/27/2019 with client #2's School Social Worker (SSW) revealed: - The school had a policy that students had to be picked up by their parents/caregivers within 30 minutes of the school contacting them; - On 2/12/2019, client #2 was removed from his school bus due to a behavioral issue; - The SSW had documentation of the exact times that school staff contacted facility staff that day; - School staff contacted the Team Leader (TL) at 2:45PM to request that facility staff pick client #2 up from the school; - The TL had informed school staff that he would pick client #2 up; - When the school did not hear back from the TL by 3:57PM, they called the TL back and he spoke to the School Principal; - At 4:08PM, the TL called the school back and said that he would be there within 30 minutes; - The Principal called the Qualified Professional instead of the TL at 4:10 to discuss concerns about facility staff not picking client #2 up in a timely manner; - The TL finally arrived to pick up client #2 at 4:50PM; - There had been other times that facility staff needed to pick clients up from school due to behavior or health emergencies, but it had taken over an hour and a half for staff to arrive; - "Our first call was supposed to be to [the TL], but that hasn't been working ..." - Following the incident on 2/12/2019, a meeting was held between the school and the QP; - The QP had said he was not aware of the issues of facility staff not picking clients up; - The school only called to have clients picked up "when it's something severe ..." Interview on 2/26/2019 with the TL revealed: - The incident with client #2 on 2/12/2019 began	V 291		

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V 291	Continued From page 3 when school staff took client #2 off of the school bus, but left client #1 and #3 on the bus; - The TL received a call from the school at 3:00PM, after the bus had left the school; - The TL spoke with the Principal and told her that he had to wait until clients #1 and #3 were dropped off at the facility by the bus before he could go to the school to pick up client #2; - The other staff scheduled to work that afternoon had been stuck in traffic; - No one else from the facility was available to pick up client #2; - The Principal had told the TL that the wait was unacceptable and that if someone did not pick up client #2 immediately, the Principal would call Protective Services; - It took approximately 20 minutes to drive from the facility to the school; - The TL had notified the QP of the incident immediately after receiving the call from the school; - The TL arrived at the school at approximately 4:40PM; - There had not been any other incidents in which clients were picked up late from school; - The timing of the incident was a big factor in the amount of time it took for the facility to respond to the school's call. Interviews on 2/25/2019 and 2/27/2019 with the QP revealed: - On 2/12/2019, client #2's Teacher thought that client #2 was going to have a behavior on the bus, so school staff kept him at school while clients #1 and #3 rode the bus home to the facility; - The TL had been the point of contact for the school; - The Teacher had called the TL and informed him that client #2 needed to be picked up at	V 291		

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V 291	Continued From page 4 school; - The TL could not leave the facility until clients #1 and #3 were safely dropped off by the bus; - The QP had talked to school staff about the situation, and was told at first that client #2 had a behavior, then that they thought he might have a behavior; - That was the only time that the QP was aware of that there was an issue with facility staff not picking up a client in a timely manner; - There was no documentation of care coordination contacts with the school in clients' records; - "We just get the calls and take care of it." - The QP did not believe that there were any problems with the coordination of care between the facility and the school.	V 291		