STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G221	A. BUILDING _____ B. WING _____	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY AVENUE HOME	112 HICKORY AVENUE HOLLY SPRINGS, NC 27540

(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 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 interview, the facility failed to ensure a client (#6) was afforded dignity regarding the use of disposable incontinence pads and clients (#1, #2, #3, #5, #6) had consents obtained by their legal guardians. This affected 5 of 6 audit clients. The findings are: 1. Client #6's dignity was not considered regarding the use of disposable incontinence pad placed underneath him as he sat. During morning observations in the home on 8/4/19 at 5:46am, a washable incontinence pad was observed placed on the chair, in which client #6 was sitting. Further observations revealed the disposable incontinence pad was visible to everyone in the home. During an interview on 8/4/19, Staff A revealed the disposable incontinence pad was placed on the chair because client #6 will have accidents. Further, Staff A commented client #6 is on a toileting schedule and he wears disposable briefs. Review on 8/4/19 of client #6's community/home life assessment dated 9/25/16 revealed he is dependent upon staff for all of his toileting needs. During an interview on 9/4/19, the qualified intellectual disabilities professional (QIDP)	W 125	This deficiency will be corrected by the following actions: A. The Clinical Supervisor and Home Manager will review client #6's ISP to ensure that the document includes mention of the use of disposable briefs and of a toileting schedule. If needed, the Clinical Supervisor will revise the ISP to include this information. B. The Clinical Supervisor will train all Direct Support Professionals on the revised ISP and how to address client #6's toileting needs with dignity. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. C. The Clinical Supervisor will review all BSPs, paying special attention to consents needed for restrictive actions/interventions and PRN medications. D. The Clinical Supervisor will ensure that any missing or expired consents for clients #1, #2, #3, #5 and #6 are updated, signed and filed in the correct medical chart. E. The Home Manager will monitor Direct Support Professionals 3x/week for adherence to providing services to the consumers in a dignified manner. F. The Clinical Supervisor will monitor Direct Support Professionals 2x/week for adherence to providing services to the consumers in a dignified manner. DHSR - Mental Health SEP 16 2019 & Cert. Section	11/2/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | Program Manager | 9/12/19

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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	34G221	A. BUILDING _____ B. WING _____	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 125	Continued From page 1 confirmed client #6 should not have been sitting on the disposable incontinence pad. 2. Consents were not signed by the legal guardians for clients #1, #2, #3, #5 and #6. During morning observations in the home on 9/4/19 at approximately 6:41am, Staff B unlocked a closet door. Further observations revealed the closet held a variety of food items. During an interview on 9/4/19, Staff B revealed the closet door is kept locked because client #2 will "eat all of the food, if he could." a. Review on 9/4/19 of client #1's record revealed a behavior support plan (BSP). Further review revealed client #1's behavior medications are: Divalproex, Haloperidol, Benztropine, Klonopin and Latuda. Additional review of client #1's record revealed the behavior medication consent was signed on 2/7/18. Further review revealed the consent for locked pantry was signed on 12/5/17, consent of usage of door alarm was signed on 2/7/18 and no consent could be located for locked freezer. b. Review on 9/4/19 of client #2's record revealed a BSP dated 6/28/19. Further review revealed client #2's behavior medications are: Depakote, Aripiprazole, Fluvoxamine, Clonazepam, Risperedone and Benztropine. Additional review of client #2's record revealed the behavior medication consent did not have a signature or a date. Further review revealed the consent for locked pantry and locked freezer did not have a signature or a date. Additional review revealed the consent of door alarm could not be located. Review of client #2's BSP did not include	W 125	Please see Page 1.	

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W 125	Continued From page 2 the usage of locking the pantry or freezer. c. Review on 9/4/19 of client #3's record revealed a BSP. Further review revealed client #3's behavior medications are: Tegretol, Neurontin and Risperdal. Additional review of client #3's record revealed the behavior medication consent was signed on 2/6/18. Further review revealed the consent for locked pantry was signed on 2/6/18, consent of usage of door alarm was signed on 2/6/18 and no consent could be located for locked freezer. d. Review on 9/4/19 of client #5's record revealed a BSP dated 6/27/19. Further review revealed client #5's behavior medications are: Escitalopram, Clonidine, Lamotrigine, Lorazepam, Quetiapine Fumarate and Melatonin. Additional review of client #5's record revealed the behavior medication consent, locked freezer consent, locked pantry consent and usage of door alarm had a signature, but were not dated. Review of client #5's BSP stated, "alarms have been placed on [Client #5'] bedroom windows and doors and are utilized with the intention of assisting staff in monitoring [Client #5] while in the home." e. Review on 9/4/19 of client #6's record revealed a BSP. Further review revealed client #6's behavior medications are: Clonidine, Risperdal and Depakene. Additional review of client #6's record revealed the behavior medication consent was not signed. Further review revealed the consents for locked pantry, locked freezer and door alarm were not signed. During an interview on 9/4/19, the facility's psychologist confirmed client #2's BSP did not	W 125	Please see Page 1.	

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W 125	Continued From page 3 include the usage of locking the pantry and the freezer. During an interview on 9/14/19, the QIDP confirmed the consents for clients #1, #2, #3, #5 and #5 have not been signed or dated. The QIDP revealed all consents expire after 1 year. Further interview revealed the QIDP was unaware of the consents for the locked freezer. Additional interview revealed the QIDP is the person who is responsible to ensure all consents are current and up to date.	W 125	Please see Page 1.	
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to document target behaviors, this affected 1 of 6 audit clients (#1). The finding is: Staff were not effectively trained regarding documenting target behaviors. During morning observations in the home on 9/4/19 at 8:58am, client #1 banged the back of his head three times against the wall in the dining room. Further observations revealed Staff D telling client #1, "Don't do that, it will give you a headache" and "Let me look, it looks fine."	W 189	This deficiency will be corrected by the following actions: A. The Clinical Supervisor and the Home Manager will provide training to all Direct Support Professionals on client #1's BSP guidelines and the procedures outlined within it. The training will also focus on accurately documenting the behaviors which are being addressed within client #1's BSP. B. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. C. The Home Manager will monitor Direct Support Professionals 3x/week for adherence to the delivery of services which meet the expectations outlined in client #1's BSP. D. The Clinical Supervisor will monitor Direct Support Professionals 2x/week for adherence to the delivery of services which meet the expectations outlined in client #1's BSP.	11/2/2019

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W 189	Continued From page 4 During an interview on 9/4/19, Staff D revealed they did not fill out an incident/accident report nor did they call the nurse. During an interview on 9/4/19, the facility's nurse confirmed staff should have filled out an incident/accident report and she should have been called in regards to client #1 banging his head against the wall.	W 189	Please see Page 4.	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of clothing, using a footstool during mealtimes and behavior management. This affected 3 of 6 audit clients (#1, #4, #5). The findings are: 1. A recommendation for the Home Manager (HM) to purchase more clothing for client #1 was not completed.	W 249	This deficiency will be corrected by the following actions: A. The Home Manager will purchase clothing for client #1 to ensure that he his needs, as outlined in his ISP, are met. B. The Clinical Supervisor will review client #1's ISP to determine if it needs revision after any identified needs have been addressed. If the ISP needs to be revised, the Clinical Supervisor will complete a revision. C. The Clinical Supervisor will review the ISP of client #4 to determine if it accurately reflects his need for a footstool while eating. While completing this review, the Clinical Supervisor will determine if the recommendation of the SLP consultant does in fact call for a footstool or if that recommendation was discontinued. D. The Clinical Supervisor will revise client #4's ISP if necessary.	11/2/2019

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W 249	Continued From page 5 During observations in the home on 9/4/19, the surveyor along with the HM looked though client #1's clothing. Further observations revealed client #1 had 9 - 10 pair of socks and there was 1 pair with holes and quite a few mixed matched socks. During an immediate interview on 9/4/19 the HM confirmed client #1 needs more socks and underwear. Review on 9/3/19 of client #1's IPP dated 5/20/19 stated, "House Manager will purchase more clothes for [Client #1]." During an interview on 9/3/19, the qualified intellectual disabilities professional (QIDP) revealed the recommendation for the purchasing of more clothing for client #1 by the HM did not occur. 2. Client #4 did not use his foot stool during meals. During meal time observations in the home on 9/3/19 and 9/4/19, client #4 did not use a foot stool during meal time. During an interview on 9/4/19, Staff B revealed using the foot stool for client #1 during meals had been discontinued. Review on 9/4/19 of client #1's IPP dated 5/3/19 stated, "OT Recommendations...foot stool to support feet during meal times...." Review on 9/4/19 of client #1's nutritional evaluation dated 7/3/19 revealed, "...foot stool at meal time."	W 249	F. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. G. The Home Manager will monitor Direct Support Professionals 3x/week for adherence to the established BSP guidelines and the documentation which follows an incident. H. The Clinical Supervisor will monitor Direct Support Professionals 2x/week for adherence to the established BSP guidelines and the documentation which follows an incident	

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W 249	Continued From page 6 During an interview on 9/4/19, the QIDP "believed" the foot stool for client #1 had been discontinued. Further interview revealed there was no documentation in client #1's chart indicating if the foot stool had been discontinued. 3. Client #5's behavior support plan (BSP) was not followed as written. During evening observations in the home on 9/3/19 client #5 had eloped with the HM following him. Further observations revealed from 6:20pm until 6:40pm, client #5 had not returned home. At 6:25pm, Staff C stated she was going to get in the van to see if she could locate client #5 and the HM. Staff C called the group home and spoke with the surveyor to inform them, client #5 and the HM were both at a local park and were currently walking back to the home. Staff on duty at the facility did not contact 911. During an interview on 9/3/19, Staff C confirmed 911 was not called, as it is written in client #5's BSP. Staff C stated she thought by calling 911 would make the situation "worse" for client #1. During an interview on 9/3/19, the HM explained there is no "manager on duty" during the week, only on the weekend and she is the manager on duty during the week. Review on 9/3/19 of client #1's BSP dated 6/27/19 stated, "One staff at home/work should contact the Manager On Call. If [Client #5] and the accompanying staff do not return in 10 minutes, the staff in the home/work will call 911."	W 249	Please see Page 6.	

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W 249	Continued From page 7 During an interview on 9/4/19, the QIDP confirmed client #5's BSP was not followed as written.	W 249	Please see Page 6.	
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on documentation review and interviews, the facility failed to ensure data was documented correctly. This affected 2 of 6 audit clients (#4, #5). The findings are: 1. Client #4's water intake log was not collected on a consistent basis. During an interview on 9/4/19, Staff B revealed client #4's water intake log should be done daily. Review on 9/4/19 of client #4's water intake log revealed for the entire month of August 2019 data was missing. Additional review revealed for the first three days in September data was missing. Review on 9/4/19 of client #4's feeding protocol (no date) revealed, "2. [Client #4] will have 3 liters of liquid daily...." Review on 9/4/19 of client #4's nutritional evaluation dated 7/3/19 revealed, "...3 lt/day fluid goal...."	W 252	This deficiency will be corrected by the following actions: A. The Home Manager and the Clinical Supervisor will review the specialized fluid intake needs of all consumers, especially client #4, to assist in training Direct Supports Professionals on those needs. B. The Home Manager and the Clinical Supervisor will review the BSPs of all consumers to prepare to train staff on correct documentation of these BSPs to include documentation of a PRN medication when it has been given. C. The Clinical Supervisor and the Home Manager will train all Direct Support Professionals on the proper use of fluid intake documentation. The Clinical Supervisor and the Home Manager will also train all Direct Support Professionals on documenting the use of PRN medications when they are given. D. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. E. The Home Manager will monitor Direct Support Professionals 3x/week to ensure that they are completing documentation as required. F. The Clinical Supervisor will monitor Direct Support Professionals 2x/week to ensure that they are completing documentation as required.	11/2/2019

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W 252	Continued From page 8 During an interview on 9/4/19, the qualified intellectual disabilities professional (QIDP) revealed the data for client #4's fluid intake should be documented as written. 2. Client #5's behavior data sheet was not documented correctly. Review on 9/4/19 of client #5's behavior data sheet revealed the box for his PRN (Pro Re Nata) medication (Lorazepam) was not documented. During an interview on 9/4/19, the home manager (HM) confirmed the data for client #5's PRN medication (Lorazepam) was missing. During an interview on 9/4/19, the QIDP confirmed the data for client #5's PRN was missing.	W 252	Please see Page 8.	
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 review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on first and third shift were not conducted at varied times. Review of fire drill reports on 9/3/19 revealed the following:	W 441	This deficiency will be corrected by the following actions: A. The Home Manager and the Clinical Supervisor will train all Direct Support Professionals on CANC Policy C6.6 Disaster/Emergency Procedures with emphasis on the procedures for running Fire Drills. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home. B. The Home Manager will monitor fire and disaster dills 1x/week to ensure they are completed accurately and at varying times. C. The Clinical Supervisor will monitor fire and disaster drills 2x/month to ensure they are completed accurately and at varying times.	11/2/2019

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W 441	Continued From page 9 Thirteen fire drills were conducted on first shift at 11:40am, 1pm, 1:54pm, 1:57pm, 1:27pm, 11am, 1pm, 10:30am, 10:15am, 10:30am, 10am, 10:30am, and 10:30am. Further review revealed twelve fire drills were conducted on third shift at 5:40am, 12:30am, 2am, 1am, 2:30am, 12:10am, 11:20am, 1am, 12:01am, 1:15am, 12am and 12:15am. During an interview on 8/3/19, the qualified intellectual disabilities professional (QIDP) stated first shift hours are between 8am thru 3pm and third shift hours are between 11pm thru 7am. Further interview confirmed first and third shift fire drills were not conducted at varied times.	W 441	D. An administrator will monitor fire and disaster drills 1x/month as part of the Site Review process.	
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected all clients residing in the home. The finding is: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During meal preparation observations in the home on 9/3/19, Staff C was observed drying their hands two different cloth hand towels. Further observations revealed two different	W 454	This deficiency will be corrected by the following actions: A. The Home Manager and the Clinical Supervisor will train all Direct Support Professionals on CANC Policy C5.26 Infectious/Communicable Disease Management. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home. B. The Home Manager will monitor Direct Support Professionals 3x/week to ensure adherence to CANC Policy C5.26 Infectious/Communicable Disease Management. C. The Clinical Supervisor will monitor Direct Support Professionals 2x/week to ensure adherence to CANC Policy C5.26 Infectious/Communicable Disease Management.	11/2/2019

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W 454	Continued From page 10 clients also drying their hands on the two cloth hand towels. Additional observations revealed one client placing his fingers in his mouth and then wiping that finger on the cloth hand towel. Observations revealed there were disposable paper towels located in the kitchen counter next to the sink. When not being used the cloth hand towels where either on the kitchen counter are placed over the shoulder of Staff C. Further observations revealed at no time did the clients or Staff C use the paper towels to dry their hands. During an interview on 9/3/19, Staff C confirmed it was not sanitary to dry their hands or the clients' hands on the cloth hand towels. Further interview revealed the paper towels should have been used. During an interview on 9/4/19, the qualified intellectual disabilities professional (QIDP) confirmed the cloth hand towel should not have been used to dry the hands of the staff and the clients. The QIDP stated the paper towels should have been used instead.	W 454	Please see Page 10.	

September 12, 2019

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction for Recertification Survey
Hickory Avenue Home, 112 East Hickory Avenue, Holly Springs, NC 27610
Provider Number: 34G 221
MHL Number: MHL-092-097

Dear Mrs. Barnes,

Thank you for your time and the feedback given during the survey you completed on September 4, 2019. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 217. Again, thank you for your time and patience.

Sincerely,

BA/QP

Gary J. Ricci II, BA/QP
Program Manager, CANC

Enclosures