| 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 _____ | R 11/22/2019 |

| 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 000 | INITIAL COMMENTS<br><br>A revisit was conducted on 11/22/19 for all previous deficiencies cited on 9/3 - 4/19. All deficiencies have not been corrected. The facility is not in compliance with all regulations surveyed. | W 000 | | |
| {W 125} | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(3)<br><br>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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure clients (#2, #3, #5) had consents obtained by their legal guardians. This affected 3 of 6 audit clients. The findings are:<br><br>Consents were not signed by the legal guardians for clients #2, #3 and #5.<br><br>a. Review on 11/22/19 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 was not in the chart.<br><br>b. Review on 11/22/19 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. | {W 125} | This deficiency will be corrected by the following actions:<br><br>A. The Clinical Supervisor will ensure that the parent/guardian of client #2 signs a consent for the use of behavior medication.<br>B. The Clinical Supervisor will file the completed consent form in client #2's chart.<br>C. The Clinical Supervisor will ensure that the parent/guardian of client #3 signs a consent for the use of behavior medication, a consent for the use of a locked freezer within the home, a consent for the use of a locked pantry at the home, and a consent for the use of door alarms in the home.<br>D. The Clinical Supervisor will file the completed consent forms in client #3's chart.<br>E. The Clinical Supervisor will ensure that the parent/guardian of client #5 signs a consent for the use of behavior medication, a consent for the use of a locked freezer within the home, a consent for the use of a locked pantry at the home, and a consent for the use of door alarms in the home.<br>F. The Clinical Supervisor will file the completed consent forms in client #5's chart.<br>G. The Clinical Supervisor will review all client charts at a minimum of annually to ensure all documentation remains up-to-date and current.<br>H. The Program Manager will conduct monthly Site Reviews to provide oversight to the Clinical Supervisor and to ensure that all client charts are up-to-date and current.<br><br>DHSR-Mental Health<br>DEC 0 9 2019<br>Lic. & Cert. Section | 12/22/2019 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: TRA/QP | TITLE: Program Manager | (X6) DATE: 11/26/19

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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| {W 125} | Continued From page 1<br>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.<br><br>c. Review on 11/22/19 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's] bedroom windows and doors and are utilized with the intention of assisting staff in monitoring [Client #5] while in the home."<br><br>During an interview on 11/22/19, the qualified intellectual disabilities professional (QIDP) confirmed the consents for clients #2, #3 and #5 were not in their charts. Further interview revealed client #2's guardian had requested revisions to his BSP, which have not been done. Additional interview revealed the QIDP had not been able to contact the guardians for clients #3 and #5 in order to obtain new consents from them. | {W 125} | Please see Page 1. | |
| {W 252} | PROGRAM DOCUMENTATION<br>CFR(s): 483.440(e)(1)<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. | {W 252} | Please see Page 3. | |

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|---|---|---|---|---|
| {W 252} | Continued From page 2<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interviews, the facility failed to ensure data was documented correctly. This affected 1 of 6 audit clients (#4). The finding is:<br><br>1. Client #4's water intake log was not collected on a consistent basis.<br><br>Review on 11/22/19 of client #4's water intake logs revealed data for 10/14/19 - 11/22/19 with only 7 days were he drank 3 liters of liquid.<br><br>Review on 11/22/19 of client #4's feeding protocol (no date) revealed, "2. [Client #4] will have 3 liters of liquid daily...."<br><br>Review on 11/22/19 of client #4's nutritional evaluation dated 7/3/19 revealed, "...3 lt/day fluid goal...."<br><br>During an interview on 11/22/19, the qualified intellectual disabilities professional (QIDP) revealed client #4 is having some difficulty with drinking 3 liters each day. The QIDP also stated there was a possibility staff were not documenting the data on a consistent basis. | {W 252} | This deficiency will be corrected by the following actions:<br><br>A. The Clinical Supervisor and/or the Home Manager will review the mealtime guidelines for client #4, with special attention paid to water intake requirements, and how to appropriately document that water intake. 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.<br>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.<br>C. The Home Manager will supervise Direct Support Professionals 3x/week to ensure adherence to client #4's water intake guidelines.<br>D. The Clinical Supervisor will supervise Direct Support Professionals 2x/week to ensure adherence to client #4's water intake guidelines. | 12/22/2019 |

November 26, 2019

Eugina Barnes
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 Follow-Up 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 November 22, 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