Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL0411151	B. WING	<u></u>	12/0	7/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ніскѕ н	OUSE OF CARE	2611 ZOL GREENSE	A DRIVE BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	The complaint (inta substantiated. A de This facility is licens category: 10A NCA	was completed on 12/7/20. ke #NC00171730) was eficiency was cited. sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
V 112	10A NCAC 27G .02 TREATMENT/HABI PLAN (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall in (1) client outcome (achieved by provision projected date of ac (2) strategies; (3) staff responsible (4) a schedule for a annually in consultation.	de developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. Include: s) that are anticipated to be on of the service and a chievement; e; review of the plan at least attion with the client or legally	V 112			
	outcome achievem (6) written consent responsible party, o	ation or assessment of				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

MHI 0411151 B. WING 12/07	
MHL0411151 B. WING 12/07	112020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2611 ZOLA DRIVE	
HICKS HOUSE OF CARE GREENSBORO, NC 27405	
	(VF)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112 Continued From page 1 V 112	
This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement a treatment plan developed based on the assessment and in partnership with the client affecting 1 of 3 clients (#1). The findings are: Review on 12/2/20 of client #1's record revealed: - An admission date of 5/1/12 - Diagnoses of Mild Intellectual Disability, Attention Deficit Hyperactivity D/O (Disorder); Bipolar D/O; Conduct D/O; Vitamin D Deficiency and Seasonal Allergies - A Behavior Support Plan (BSP) developed by a Licensed Psychological Associate (LPA) on 6/28/19 and last revised on 10/6/20 - The BSP included this addendum dated 10/6/20: "[Client #1] requested independent time away from the residential setting. The team agreed on the following: 1. [Client #1] will sign out and back in from the residential home. 2. He agreed to ride his blike up to 30-45 minutes up to 7 days per week in his neighborhood [names of the streets client #1 was to travel], making a circle. 3. If he does not return within the 45-minute time frame, staff will drive the route to look for him. 4. If there is an incident which causes [client #1] to get irritated, he will leave that immediate area immediately and call staff. 5. If there is an incident which threatens his safety in any way, he will immediately leave that area and call staff. 6. If there is any type of incident (safety, frustration, not back within 45 minutes time period, goes somewhere other than agreed upon route), the team will meet before he	

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STATE FORM SZBH11 If continuation sheet 2 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL0411151	B. WING		12/0	7/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HICKS H	OUSE OF CARE	2611 ZOL		7.05		
			BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 112	Continued From pa	ige 2	V 112			
	again"					
		as signed by client #1; the				
		Qualified Professional (L/QP)				
		's Care Coordinator,				
	Community Naviga	tor and the LPA				
	Review on 12/7/20	of the same BSP developed				
		addendum dated 11/6/20				
	revealed:					
		requested to change the route				
		ent #1] will sign out and back				
		tial home. 2. He agreed to ride				
		5 minutes up to 7 days per orhood. The route he will take				
		Food Lion near his home and				
		not return within the 45-minute				
		Il drive the route to look for				
		e located, staff will call the				
		an incident which causes				
		tated, he will leave that				
	and call staff.	mediately, take deep breaths				
		dent which threatens his				
		ne will immediately leave that				
		6. If there is any type of				
	,	stration, not back within 45				
		d, goes somewhere other than				
		the team will meet before he es the residential home again.				
	7. He only has one					
		per day. If he returns at the				
		and wants to go again, staff				
	will go with him. As	long as staff is with [client #1],				
		ices not on this route chosen				
		ne team will discuss [client				
		ollowing the rules and taking				
		s actions and then expanding me based on this progress at				
	every team meeting					
		as signed by client #1; his				

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STATE FORM SZBH11 If continuation sheet 3 of 12

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
ANDILAN	OF CONTROL	IDENTIFICATION NOWIDER.	A. BUILDING:		COIVI	LLTLD
		MHL0411151	B. WING			C 07/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
1110140 11	OUGE OF CARE	2611 ZOL	A DRIVE			
HICKS H	OUSE OF CARE	GREENS	BORO, NC 2	7405		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	ECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETE DATE
V 112	Continued From pa	age 3	V 112			
	facility's L/OD as w	all as client #1's Care				
		ell as client #1's Care nunity Navigator and the LPA				
	·	, ,				
		and on 12/2/20 of the client				
	_	rm" from 10/8/20 to 12/2/20				
	revealed:	#1 signed out (no time listed)				
		tion of what time he returned				
	to the facility;	non or what time he returned				
		tion of client #1 signing out or				
	in from 10/9/20 to 1	10/21/20;				
		t #1 signed out between 4:00				
	·	eturned to the facility at 5:26				
	pm 40/22/20 aliant	t #4 signs of suit at 12:20 mm				
		t #1 signed out at 12:30 pm tion of what time client #1				
	returned to the faci					
		tion of client #1 signing out or				
	in from 10/24/20 to					
	- 11/10/20, client	t #1 signed out at 1:46 pm. No				
		vhat time client #1 returned to				
	the facility was liste					
		t #1 signed out at 2:12 pm. No				
	the facility was liste	what time client #1 returned to				
		:u, :#1 signed out at 2:41 pm and				
	returned to the faci					
		#1 signed out at 4:58 pm. No				
		what time client #1 returned to				
	the facility listed;					
		t #1 signed in at 3:24 pm. No				
		vhat time client #1 signed out				
	of the facility listed;	t #1 signed out at 4:37 pm and				
	returned to the faci	•				
		t #1 signed out at 11:43 am				
		facility at 12:58 pm				
		11/15/20 to 12/2/20, client #1				
	signed out and in o	n the facility's "monitoring				
		and returned to the facility				

Division of Health Service Regulation

STATE FORM SZBH11 If continuation sheet 4 of 12

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
71101010	OF CONTROL OF THE CON	BENTI TOXTTON NOWBER.	A. BUILDING:			
		MHL0411151	B. WING		12/0	7/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	Interview on 12/1/2 In October 2 team agreed he cor "thirty-five minutes" pre-determined rou Client #1 stated day, with weather p When aske time was going, clie little confusion." Client #1 re regarding the amou from the facility and when riding his bicy The L/QP a him to ride his bicy	d about how his unsupervised ent #1 stated, "First time, a eported the "confusion" was int of time he could be away I the route he was to take vole nd facility staff had allowed be numerous times during the rty-five to forty-five minutes				
	- He had bee center and returning was supposed to - When he sponsed to reminded this was during his 10/6/20 to leave the facility be away from the faminutes - After his Ca Community Navigathe guidelines regathe community, he again in November - Since the November of the community was now allowed to the supposed to th	n riding to a local shopping g to the facility later than he coke with his Community Care Coordinator, he was it what had been agreed upon reatment team meeting in the what agreed upon during QP and staff had allowed him multiple times per day and to acility longer than forty-five are Coordinator and tor realized he wasn't following riding his unsupervised time in and his treatment team met				

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STATE FORM SZBH11 If continuation sheet 5 of 12

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		MHL0411151	B. WING			7/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DDECC CITY O	STATE, ZIP CODE	•	
NAIVIL OI I	FINOVIDEIX OIX SUFFEIEIX			STATE, ZIF CODE		
HICKS H	OUSE OF CARE	2611 ZOL		7405		
			BORO, NC 2			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 112	Continued From pa	ge 5	V 112			
	-					
		e could only go out once per				
		ın forty-five minutes				
		e some issues because [the				
		unicating (about where he				
		long he could be away from				
	the facility) with stat					
		confused, and I was				
	confused."	e no issues now that				
	everybody is on the					
		lowing the guidelines. He				
		e followed the rules, his				
		in the community might be				
	increased	in the community might be				
	- "This is a test."					
	Interview on 12/1/2	0 with staff #1 revealed:				
	- When client #1	was first allowed to have				
	unsupervised time i	in the community, he did not				
	follow the guideline	S				
		red he could go out more than				
		de his outside of the route he				
	was supposed to fo					
		before the boss man (L/QP)				
		st figured out what they				
	needed to do."	o probleme when he weet and				
		o problems when he was out				
		es just that he was going out ng out longer than he was				
	supposed to	ig out longer than he was				
		tment team met in November				
	2020 and the guide					
		were explained to client #1				
	again	ito. o oxplained to ellerit if i				
		er staff, including the L/QP had				
		ining conducted by client #1's				
	LPA on his BSP wit					
		ow following the guidelines				
		riding his bike to the local				
		ack and returning to the				

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Division of Health Service Regulation

DIVISION	Of Fleatill Service IN	squiation	1			1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						`
		MUI 0444454	B. WING			
		MHL0411151			12/0	7/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2611 ZOL	A DRIVE			
HICKS H	OUSE OF CARE		BORO, NC 2	7405		
			JORO, NC 2			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
IAO		,	IAG	DEFICIENCY)		
V 112	Continued From pa	ge 6	V 112			
	facility within forty fi	ive minutes) without any				
		ive illilutes) without any				
	difficulty.					
	Interview on 19/1/9	0 with staff #2 rayaalad				
		0 with staff #2 revealed:				
		Illowed to begin riding his bike				
		rision in October 2020				
		1 followed the guidelines				
	established in his B					
		but then he began to "take				
		tuation" and started asking				
		't be away from the facility				
		eed upon thirty minutes				
		began riding his bike outside of				
	the route and wante	ed to go out to ride his bicycle				
	multiple times per c	lay				
	- His treatment to	eam met in November 2020				
		ent #1 that it was one time per				
	•	es to forty-five minutes a day				
		now ride his bike to the local				
	grocery store and the					
		stop and interact with anyone				
	while out riding his					
		er staff, including the L/QP had				
		ining conducted by client #1's				
	LPA on his BSP wit					
		een following the guidelines				
		pervised time and had not had				
	any problems	os. Nosa amo ana naa not naa				
		into nothing, he doesn't				
	bother anybody."	. Into Houling, he doesn't				
	bother arrybody.					
	Interview on 12/2/2	0 with client #1's Community				
	Navigator revealed:					
		ctober 2020 treatment team				
		ided that client #1 ride his				
		r day for no more than				
	forty-five minutes					
		o ride his bike on a				
		te in his neighborhood				
	 She learned from 	om client #1's Care				

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Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						;
		MHL0411151	B. WING			7/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ніскѕ н	OUSE OF CARE	2611 ZOL				
			BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 112	Continued From pa	ge 7	V 112			
	and client #1 was b route and to go out his bicycle - Another treatment 11/16/20 to address enforce client #1's IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	erned that staff including the ring that client #1 followed the to his unsupervised time in higher functioning; however, he setting into physical ners was reiterated to the L/QP endance that client #1's BSP o keep client #1 safe and out of ment team meeting in the LPA had met with the higher than them on client #1's BSP and find client #1 had been				
	Coordinator revealed - During the 10/6 held on behalf of clithat client #1 could day for no more that was to follow a preneighborhood - On 11/14/20, storm client #1 becan hard time" and he we - Client #1 report to leave the facility bike without staff becan share the staff becan share	s/20 treatment team meeting ient #1, it was agreed upon ride his bicycle one time per an forty-five minutes and hedetermined route within his ne received a telephone call use a staff was "giving him a vanted her to talk with him ted that staff did not want him more than once to ride his				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
		A. BUILDING:			_
	MHL0411151	B. WING			C 0 7/2020
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HICKS HOUSE OF CARE	2611 ZOL GREENSE	A DRIVE BORO, NC 2	27405		
(X4) ID SUMMARY S	FATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORREC	LIUN	(X5)
PREFIX (EACH DEFICIENT	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
V 112 Continued From p	page 8	V 112			
meeting - She also spoke of the guidelines the went out for a large of the went out take or that with others while of lient #1 shad that she would team meeting to a large of lient #1's Common the LPA in attendary of lient #1's history and his BSP regarding the community - She was unclusted in facility had requirements writted the large of lient #1's history and the staff on a large of lient #1 getting someone while here a large of lient #1 getting someone while here a large of lient was follow to the large of lient #1 getting someone while here a large of lient was follow the large of lient #1 getting someone while here a large of lient was follow the large of lient was followed to the large of lient was follo	the with the staff if he was aware that client #1 was to follow when bricycle ride in the community not aware of the route client #1 to he should have no contact on his bicycle ride stioned her as to why staff of allowed him to go out multiple this bicycle if this was not what happen at she had the same question dischedule another treatment discuss what was happening that #1, the Care Coordinator, unity Navigator, the L/QP and the atment team meeting, it was longly and client #1 that because ry of getting into physical of thers, it was important that there to the guidelines listed in the with his unsupervised time in the ear as to why the L/QP and the not held client #1 to the				

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DIVISION	of Health Service Re	eguiation				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_ ا	<u> </u>
		MIII 044444	B. WING		(
		MHL0411151	D. WING		12/0	7/2020
NAME OF F	PROVIDER OR SUPPLIER	STREFT AD	DRESS, CITY S	STATE, ZIP CODE		
				····-, -·· • • • • • • • • • • • • • • • • • •		
HICKS H	OUSE OF CARE	2611 ZOL		7.405		
		GREENSI	BORO, NC 2	7405		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIAIE	DAIL
				- ,		
V 112	Continued From pa	ge 9	V 112			
	·					
		ions listed in the BSP without				
	incident.					
		0 with the LPA revealed:				
		#1's treatment team had met				
		ss client #1's request for				
	unsupervised time i	in the community				
	- The treatment t	team and client #1 agreed that				
		his bicycle for at least				
		aily, seven days per week				
		ilso to follow a pre-determined				
		ghborhood while on his bicycle				
	ride	g				
		t that client #1 follow the				
		supervised time as client #1				
		nibiting physical aggression				
	towards others	libiting physical aggression				
		d to train the staff at the facility				
		d to train the staff at the facility				
		on multiple occasions; prior to				
		upervised time; however, the				
		o allow her to conduct the				
	training					
		w agencies that will not take				
		to train their staff and "[the				
	L/QP] was one of th					
		usion regarding client #1's use				
		I time, she and client #1's				
		et in November and modified				
		ent #1's request for a change				
	in his route					
	- The L/QP agree	ed to allow her to train his staff				
	how to best work w	ith client #1 to include how to				
	address the situation	on, if client #1 failed to follow				
		ed to his unsupervised time				
	•	ne staff via telephone on				
		d them on client #1's BSP				
		a good training and felt the				
		od how to utilize client #1's				
	BSP when working					
	POI MILELL MOLKING	WILL FILLE.				

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Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL0411151	B. WING		12/0	7/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	01105 05 04 05	2611 ZOL	A DRIVE			
HICKS H	OUSE OF CARE	GREENSE	BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 10	V 112			
V 112	Interview on 12/7/2 - During client #* 10/6/20, it was cleat he could use his uncommunity - Client #1 knew pre-determined rout was not to stop and community - Client #1 also keepend on time per day forminutes on his bicty - Once client #1 time in the communapp" (Global Position use on his and client - This "GPS app #1's location at all the realized following his assign had stopped at a new basketball, per client with client #1 and in Navigator about client He did not realigned had not shared this Care Coordinator of team meeting held - During the treat 11/16/20, client #1's desire to local grocery store) options for staff to fit to follow the rules retime in the community - On 11/18/20, the	O with the L/QP revealed: I's treatment team meeting on rly explained to client #1 how is supervised time in the he was to ride his bicycle on a te in his neighborhood and he dengage with others in the knew that he was to go out only or no more than forty-five cle was granted unsupervised nity, he purchased a "GPS oning System application) to not #1's cell phones " allowed him to know client imes the droute and on one occasion, eighbor's house (to play not #1), he addressed the issue and formed client #1's Community the entire of the Community Navigator information with client #1's r his LPA prior to the treatment on 11/16/20 the team meeting on the BSP was revised to address of change his route (to ride to a sa well as to document follow when or if client #1 failed delated to his unsupervised	V 112			
	client #1 had been	6/20 treatment team meeting, following the guidelines for his and there has been no				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		MHL0411151	B. WING		12/0	7/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		
ніскѕ н	OUSE OF CARE	2611 ZOL GREENS	.A DRIVE BORO, NC 2	27405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 11	V 112			
	problems.					
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