DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2021
FORM APPROVED
OMB NO. 0938-0391

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 _____	03/25/2021

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 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure two incidents of elopement were thoroughly investigated. This affected 1 of 3 audit clients (#5). The finding is: During observations on 3/24/2021 and 3/25/2021 there was an unlocked gate in the back of the house and no gate or fence in the front of the house. Observations during the afternoon, on 3/24/02021, revealed an alarm kept sounding while client #5 was in the back of the house. No staff responded to it until the surveyor asked what it was. Interview on 3/24/2021, after being asked what the alarm was for, the qualified intellectual disability professional (QIDP), group home manager and all staff stated that was just client #5 moving around in his bedroom. When asked what it was addressing, they all stated that he elopes. When asked if they should check it, all staff (including the QIDP) indicated there was no need to check the alarm. However, the group home manager went after the interview and checked on client #5. Review on 3/24/21 of client #5's behavior support plan (BSP) revealed he is on a plan which addresses aggression, inappropriate toileting, non-compliance and elopement with the restrictive techniques of medications and alarms	W 154	W 154 This deficiency will be corrected by the following action: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manage inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain guardian consent. F. Qualified Professional will have consented BSP reviewed and signed by HRC representative G. All staff will be in-serviced on all Behavioral Support Plans and proper documentation. H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week	4/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamika Johnson TITLE: Program Manager (X6) DATE: 3/29/2021

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 154	Continued From page 1 The plan has not been revised in regards to elopement since it was written on June 27, 2019. Elopement was defined as "leaving or attempting to leave designated area without escort." The guidelines for elopement included, "Staff should provide the appropriate supervision to prevent the possibility of elopement." It also indicated, "alarms have been placed on [Client#5's] windows and doors and are utlized with the intention of assisting staff in monitoring [Client #5] while in the home." It also indicated a manager on call should be notified if he does not return in ten minutes. During an interview on 3/24/21, with the group home manager, when asked when was client #5's last elopement she stated it was on this past Sunday. She was asked to provide all elopement incident reports for the past year. Review on 3/25/2021 of the elopement incident reports revealed an incident of elopement for Client #5 on 3/21/2021. Client #5 became agitated and he "Ran out opened the gate and eloped." After not being able to get him the staff called the police who brought him back. Prior to that on 5/23/2020, another incident report indicated client #5 became agitated and left the home. It did not indicated how he left. However, staff followed him in the vehicle keeping eyesight of him at all times. When he refused to come back, the police was called. The police returned him but he did not go into the home without being VSIS (staff defined as a safe physical hold) to carry him inside. This report included a clinical supervisory review which stated, "BSP to be edited to include locks on front gate at home to ensure safety. Follow elopement guidelines in BSP."	W 154		

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W 154	Continued From page 2 Review on 3/25/2021 of both incident reports for elopement of client #5 did not indicate if the elopement guidelines were followed prior to each elopement . The indicant report noted that on 5/23/2021 a lock should be placed on a gate. The incident report on 3/21/2021 noted, he ran out the gate. Neither report indicated if management was notified or how long client #5 was gone. Interview with the QIDP on 3/25/2021 indicated he was not the QIDP at the time of the first elopement. He further indicated no investigation of the incidents occurred that he knows of but they were reviewed. He did not know about the lock recommendation. He further confirmed the behavior program was not revised to address the gate.	W 154		
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 interview, the facility failed to ensure staff were appropriately trained to respond to the alarm for the restrictive program for 1 of 3 audit client (#5). The finding is: During observations in the afternoon on 3/24/02021, an alarm kept sounding while client #5 was in the back of the house. No staff	W 189	W 189 This deficiency will be corrected by the following action: A. Staff will be in-serviced on the protocol and procedure for responding to all alarms in the home. B. Site Supervisor will monitor one time a week. C. Qualified Professional will monitor one time a week	4/23/2021

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W 189	Continued From page 3 responded to it until the surveyor asked what it was. Interview on 3/24/2021, after being asked what the alarm was for the qualified intellectual disability professional, group home manager and all staff stated that was just client #5 moving around in his bedroom. When asked what it was addressing, they all stated that he elopes. When asked if they should check it, all staff (including the QIDP) indicated there was no need to check the alarm. However, the group home manager went after the interview and checked on client #5. Review on 3/24/21 of client #5's behavior support plan (BSP) revealed he is on a plan which addresses aggression, inappropriate toileting, non-compliance and elopement with the restrictive techniques of medications and alarms. During an interview on 3/24/21, with the group home manager, when asked when was client #5's last elopement she stated it was on this past Sunday. Further interview with the qualified intellectual disabilities professional (QIDP) confirmed client #5 has alarms to alert the staff when he may be eloping but they knew he was not because he was in his room walking around. He did acknowledged they should probably check the alarms.	W 189		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure restrictive program for 1 of 3 audit clients (#5) was conducted with the written informed consent of a legal guardian. The finding is: During observations in the afternoon on 3/24/02021, an alarm kept sounding while client #5 was in the back of the house. Review on 3/24/21 of client #5's behavior support plan (BSP) revealed he is on a plan which addresses aggression, inappropriate toileting, non-compliance and elopement with the restrictive techniques of medications and alarms. A review of the consent revealed it was last signed by the guardian on 12/22/19. It noted the consent expires 6/27/20 and that "plans containing restrictive interventions must have written consent from all parties every 6 months." During an interview on 3/24/21, the qualified intellectual disabilities professional (QIDP) confirmed client #5's record did not include updated BSP consents, which were signed by his guardian. He indicated all of their consents form have an expiration date and they should be updated before the expiration date. Further interview revealed the facility has been made aware of their need for revamping their process for updating consents. The QIDP stated the psychologist is the responsible person to ensure consents are done in a timely manner and she is failing at this..	W 263	W 263 This deficiency will be corrected by the following action: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manage inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain guardian consent. F. Qualified Professional will have consented BSP reviewed and signed by HRC representative G. All staff will be in-serviced on all Behavioral Support Plans and proper documentation. H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week	4/23/2021
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE	W 352		

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W 352	Continued From page 5 CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a dental examination for 1 of 3 audit clients (#1) occurred no less frequently than annually. The finding is: Review on 3/24/2021 of client #1's record revealed a dental exam dated 9/3/19. However, this exam was his last dental screening. No other examination was located in his record. Interview with nursing and the qualified intellectual disability professional (QIDP) on 3/24 and 3/25/2021 confirmed there was no other dental examination conducted for client #1. They confirmed it was over a year and did not indicated that an appointment is scheduled. The QIDP acknowledged a dental screening should be done at least annually.	W 352	W 352 This deficiency will be corrected by the following action: A. The Site Supervisor will ensure that individuals are scheduled and attend all diagnostic services to include periodic examinations and diagnosis appointments at least annually. B. The nurse will be responsible for ensuring this is happening and documenting monthly. C. The Qualified Professional will be responsible for monitoring and documenting this is happening monthly.	4/23/2021

1001 Navaho Dr., Suite 101
Raleigh, NC 27609
PHONE: (919)387-1011
FAX: (919)387-1130

Community Alternatives-NC

Fax

To: Joy Alford **From:** Juanita Jefferson

Fax: (910) 715-8078 **Pages:** 8 (including cover)

Phone: (919) 554-8021 9-6052 **Date** 3/29/2021

Re: Hickory Avenue RDC **cc:**

☐ Urgent ☑ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Have a great week!

March 30, 2021

Joy Alford
Facility Consultant 1
Mental Health Licensure & Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718
919.605.4336 M
919.715.8078 F

Re: Survey Completed March 25, 2021
Hickory Avenue Group Home
112 Hickory Avenue
Holly Springs, NC 27540
Provider Number 34G2221
MHL# -092-097

Dear Mrs. Alford

We appreciate the courtesy extended by you while surveying the Hickory Avenue Group Home, North Carolina.

As indicated the Plan of Correction, we have will have the deficiencies corrected for the Annual Survey Conducted on **March 25, 2021** it will be completed by **May 23, 2021**.

We are committed to providing the highest possible care for the people we serve at Hickory Avenue Group Home.

If you have any questions, please contact Cynthia Bradford, Associate Executive Director at 984.205.2630 ext. 238.

Kind Regards,

Cynthia Bradford, Associate Executive Director
Community Alternatives North Carolina- Raleigh Region
1001 Navaho Drive, suite 101
Raleigh, NC, 27609
276.252.8193
984.205.2630 ext. 403
Cynthiabradford@rescare.com