

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

PRINTED: 08/13/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/13/2021
NAME OF PROVIDER OR SUPPLIER HICKORY AVENUE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	W 000		
W 249	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a continuous active treatment program provided necessary supports for 1 of 1 audit client (#1). The finding is:</p> <p>Review on 8/13/21 of the police reports from the local law enforcement agency for the dates 6/3/21-8/7/21 for the address of the facility law enforcement officers responded to the following calls:</p> <p>A) 6/3/21: (1:29)Other call- Address: Local Park B) 6/4/21 (4:44) Check on Welfare- Address: Local Park C) 6/15/21 (12:25) Missing Person-Adult- Address: Local Park D) 7/5/21 (12:35) Check on Welfare- Address:</p>	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 249	<p>Continued From page 1</p> <p>Local Park</p> <p>E) 7/12/21 (12:14) Suspicious Person - Address: Local Park</p> <p>F) 7/12/21 (4:06) Suspicious Person- Address: Local Park</p> <p>G) 7/13/21 (5:39) Suspicious Person- Address: Local Park</p> <p>H) 7/16/21 (12:34) Escort/Transfer- Address: Address of facility</p> <p>I) 7/21/21 (1:00) Check on Welfare- Address: Address of facility</p> <p>J) 7/27/21 (8:28) Other call- Address: Local Park</p> <p>K) 8/7/21 (2:27) Check on Welfare- Address: Local Park</p> <p>During observations at the home on 8/12/2021 at 9:00am, the side door located near the kitchen in the facility was noted not to have a working alarm. Client #1 has two windows in his bedroom. Observation of both windows revealed one of the windows also did not have a working alarm. There was a check list to assure all alarms were working observed to be posted in the office. This list had been checked off routinely. 8/12/2021 had not been checked yet. Staff A then went and checked all alarms finding the side door alarm off and turned it back on.</p> <p>Interview with staff A about the alarms revealed she usually checks all alarms mid morning. She indicated that the side door is never used. She further stated that client #1 does not elope out that door. She did not know how the alarm got turned on but she has been working for the company for nearly 15 years and client #1 has not used that door to elope.</p> <p>Review on 8/12/2021 of the individual program</p>	W 249			

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W 249	<p>Continued From page 2</p> <p>plan (IPP) dated 8/15/2020 revealed that there is a program to address the behavior of elopement.</p> <p>Review on 8/12/2021 of the behavior support plan (BSP) dated June 27, 2019 revealed that client #1 has "elopement (attempts)." It noted that these attempts are controlled through the use of alarms. It did not specify where the alarms would be located. Elopement was defined as "Leaving or attempting to leave designated area without escort." The plan indicated elopements attempts should be reported to the on call manager. It noted that if client #1 does not return with staff within 10 minutes the staff should call 911. Additionally, a client incident report should be completed for each attempt as well as documented on the behavior data record. The record of data indicated the following elopement behaviors had been documented: 7/13/2021, 5/28/2021, 3/21/2021, 4/20/2021, 4/19/2021</p> <p>Interview with staff A revealed client #1 has gone out of the home to the park with staff following several times. She did not know how many times. She stated staff "always follow behind him keeping him in sight."</p> <p>Interview with staff B indicated client #1 has gone out of the home to the park with staff following several times. She indicated she has been the staff to follow him on occasions.</p> <p>Interview with staff C who worked at this home for 15 years indicated client #1 has run out of the home but to their knowledge never without staff following him. She stated she followed him for most of the July incidents. She indicated she called the non-emergency number for the police and waited for the police to come get him. She</p>	W 249			

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W 249	<p>Continued From page 3</p> <p>stated she remained on the phone with the non-emergency receptionist at the police department. She confirmed during this phone interview that she was most likely on duty and the one following client #1 on 7/5, 7/13, 7/16, 7/21. She could not remember past that time.</p> <p>Interview with staff D who worked third shift for over a decade was aware that client #1 elopes but stated he does not elope on third shift. She also indicated that as far as she knows staff always follows behind him when he leaves and he goes to the park.</p> <p>Interview with staff E who worked third shift for 26 years was aware that client #1 elopes but stated he does not elope on third shift. She also indicated that as far as she knows staff always follows behind him when he leaves and he goes to the park.</p> <p>Interview with staff F who worked third shift for 14 years was aware that client #1 elopes but stated he does not elope on third shift. She also indicated that as far as she knows staff always follows behind him when he leaves and he goes to the park. She stated when getting off one morning in July she saw him leave and saw staff right behind him. She was walking.</p> <p>Interview with staff G revealed on second shift client #1 has eloped and he has followed him on foot. He indicated when he leaves he does not have to call the police to get him to come back and he stays with him the whole time. He also revealed that the staff have always gone with or followed behind client #1.</p> <p>Interview on 8/12/21 with a Sergeant with the</p>	W 249		

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W 249	<p>Continued From page 4</p> <p>local law enforcement entity revealed that client #1 has eloped from the facility numerous times in the past several months. Further interview revealed staff from the facility have contacted the police department repeatedly to assist with client #1 in transporting him back to the facility. Additional interview revealed during several of these calls, client #1 has been located alone in a local park or on a nearby street and facility staff arrived at the time law enforcement arrived or sometimes after law enforcement had already located client #1. The Sergeant indicated law enforcement has expressed concern to facility staff that a major traffic intersection is within a half a mile of the facility and they are concerned for client #1's safety, given his lack of safety skills.</p> <p>During an interview on 8/12/2021, the qualified intellectual disability professional (QIDP) revealed that he was not been notified of any additional times of client #1 eloping. He also presented an addendum "Clinical Supervisory Note." This note indicated there had been an increase in elopements in the past quarter. The team noted that they had met to discuss this increase and had discussed the elopements and found that he "always goes to the park. Staff keeps their eyes on him, but [Client#1] behavior is elevated and he refuses to return with staff and he states that he wants the police to come pick him up. When the police arrive to pick [client #1] up, his mood often deescalates and he will return.... To address [Client #1's] elopement behavior, the first strategy is to increase the time [he] is able to spend appropriately at the park." Another suggestion was made to work with the local police department to give [him] an opportunity to ride along with a police officer."</p>	W 249			

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W 249	Continued From page 5 Interview on 8/12/2021 with management on 8/12/2021 revealed the team has not yet met with the police department to discuss "ride alongs." Further interview on 8/12/2021 with the QIDP confirmed the BSP has not been revised. He also confirmed that his current comprehensive functional assessment remained accurate when it noted he was dependent on staff for safety skills.	W 249			