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	34G248	A. BUILDING _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLINGSWOOD GROUP HOME	214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to exercise general operating direction over the facility by failing to maintain the facility van's lift safety system for 2 of 4 sampled clients (#1 and #3). The finding is: Observations in the group home on 8/18/21 at 8:50 AM revealed staff D to transfer client #3 into the facility van using the van lift. Further observations revealed staff D to extend and manually hold the safety strap of the lift in place behind the client while the van lift raised client #3 onto the van. Subsequent observation at 9:00 AM revealed staff C and D to transfer client #1 onto the facility van using the van lift. Further observations revealed the safety strap could not be secured behind the client as the attachment to fasten the belt was broken. Continued observation revealed staff D to manually hold the safety strap in place until the van lift raised client #1 onto the van. Interview with staff D on 8/18/21 verified that the van security strap fastener had been broken for at least a year. Further interview with staff D verified that at times the van lift will stall and staff will need to manually lift and lower the van lift in place. Further interview with staff D verified that staff have submitted several calls and emails to management about the security strap and van lift needing to be repaired.	W 104		

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

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W 104	Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that she was aware that the van lift needed to be serviced, however she could not locate the work order at the time of the survey. Further interview with the QIDP and facility administrator verified that the facility would make sure that the van lift and safety strap fastener were repaired, however, no date was available as to when the items would be serviced. It should be noted on 8/18/21, after observations and initial interviews, the facility administrator reported to the survey team the facility van had been repaired and that moving forward all clients are able to be safely transported.	W 104		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy during client care for 1 of 4 sampled clients (#4). The finding is: Morning observations in the group home on 8/18/21 at 7:30 AM revealed client #4 to enter the bathroom with staff assistance. Further observation at 7:55 AM revealed staff B to exit the bathroom and enter into client #4's bedroom leaving the bathroom door ajar. Observations revealed client #4 to sit on the toilet fully	W 130		

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W 130	Continued From page 2 unclothed which could be seen from the hallway. Continued observation revealed staff B to return to the bathroom with client #4 and to close the door behind her. Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that client #4 should not have been left alone in the bathroom, unclothed, with the door ajar. Further interview with the QIDP confirmed that all clients should be offered privacy during care and treatment.	W 130		
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff were adequately trained specific to supervision to support client safety for 3 of 4 clients (#2, #3, #4. The finding is: Observation at the group home on 8/18/21 at 8:35 AM revealed all clients to be outside the group home and attempting to load the van for transport to the vocational program. Continued observation at 9:58 AM revealed clients #2, #3 and #4 to sit on the facility van, with staff F, with the vehicle running. Further observation revealed staff F to leave the facility van, while the vehicle was still running, to go to her personal car leaving all clients on the van unsupervised for (5) minutes. Subsequent observation revealed staff D to exit from the group home and to get into the driver seat of the van to support the supervision	W 191		

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W 191	Continued From page 3 needs of all clients on the van. Review of records on 8/18/21 for clients #2, #3 and #4 revealed behavior programs with the need for close supervision. Interview with staff D on 8/18/21 verified clients should not ever be left on the facility van unsupervised, especially if the vehicle is running. Interview with the facility administrator and qualified intellectual disabilities professional (QIDP) on 8/18/21 verified client safety should be a priority and clients should never be left unattended on a running vehicle.	W 191		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on review of records and interview, the person centered plan (PCP) failed to have sufficient training or interventions to meet identified needs for 2 of 4 sampled clients (#1 and #4). The findings are: A. The facility failed to have a training program to address the safety of client #4 relative to transportation guidelines. For example: Afternoon observations in the group home on 8/17/21 at 4:30 PM revealed client #4 to enter the group home from a van ride wearing a gait vest and no shoes. Further observations from 4:30 PM to 5:30 PM revealed client #4 to participate in	W 227		

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W 227	Continued From page 4	W 227		

various activities that included participating in the dinner meal and to exhibit escalating behaviors such as crawling on the floor, screaming, crying and throwing objects at staff and peers. Continued observations revealed staff E to escort client #4 to the facility van for a van ride due to escalating behaviors. Subsequent observation revealed staff E to secure client #4 to a harness attached to a seat on the van and client #4 to remain barefoot. Additional observation revealed staff E and the qualified intellectual disabilities professional (QIDP) to leave the facility with clients #4 and #2 to take a van ride.

Morning observations in the group home on 8/18/21 from 6:30 AM to 8:45 AM revealed client #4 to participate in various activities such as grooming and participating in the breakfast meal. Further observations revealed client #4 to exhibit escalating behaviors and staff D to escort the client to the facility van to transport clients to the vocational program. Continued observations revealed staff to secure client #4 to the harness attached to a seat on the van and the client to sit on the van barefoot waiting to leave the group home.

Review of records for client #4 on 8/18/21 revealed a person centered plan (PCP) dated 5/21/21. Further review of the record revealed a behavior support plan (BSP) dated 6/2/21 which indicated that client #4 exhibits target behaviors such as unsafe travel, removing clothing, pushing/pulling others, being uncooperative, self-injurious behaviors (SIBs) and leaving a supervised area. Continued review of the BSP indicated that client #4 responds well to frequent van rides which aid in de-escalating behaviors. Review of the record did not reveal transportation

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W 227	Continued From page 5 guidelines for client #4. Interview with staff D on 8/18/21 verified that client #4 has difficulties during transportation and will exhibit head banging. Interview with the QIDP verified that client #4 has transportation difficulties and the client is required to wear a gait vest connected to a travel harness to ensure safety during transportation. Further interview with the QIDP verified that staff have a hard time getting client #4 to wear shoes, which can often lead to escalating behaviors. The QIDP also verified during the interview that at times staff will stop the van to address client #4's behaviors. Interview with the QIDP confirmed that all of client #4's goals and interventions are current. Interview with the QIDP also confirmed that client #4 could benefit from transportation guidelines to ensure the client's safety during transportation. B. The facility failed to have guidelines to address safety of client #1 relative to wheelchair transfers. For example: Observations in the facility on 8/18/21 at 7:07 AM revealed client #1 to sit at the kitchen table in her wheelchair with no seatbelt or gait belt. Continued observation revealed client #1 to look at staff A and request the staff to bring the client her gait belt from her bedroom. Further observation revealed staff A to walk to client #1's bedroom, to access the client's gait belt and return to the dining room to assist client #1 with putting her gait belt around her waist while the client remained in her wheelchair. Subsequent observation at the group home on 8/18/21 at 8:35 AM revealed all clients to exit the group home to begin loading the facility van for	W 227		

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transport to the vocational program. Continued observation revealed staff C and staff F to assist client #1 with loading the van and staff F to attempt a (1) person transfer of client #1 from her wheelchair to a seat on the facility van. Further observation, after interview with staff C, revealed staff C to assist staff F with a (2) person transfer of client #1 from her wheelchair to a seat in the van.

Review of records on 8/18/21 for client #1 revealed a nursing note dated 12/30/20 that revealed client #1 was sent to the local emergency room after a behavior; fracture of pelvis and referred to Ortho Carolina. Continued review of nursing notes revealed on 12/30/20 client #1 is using a wheelchair and (2) person assist from wheelchair to toilet and bed. Further record review for client #1 revealed a mini-team report dated 4/7/21 that revealed the team met to discuss client #1's current situation; Ability to walk has decompensated since she has been required to be wheelchair bound with no weight bearing since pelvic fracture. Client #1 continues to remove her seatbelt and stand, slides out of wheelchair putting herself at serious risk of fracturing a bone.

Interview with staff C on 8/17/21 revealed client #1 is a (2) staff transfer due to the client's weight. Interview with the facility qualified intellectual disabilities professional (QIDP) on 8/17/21 revealed client #1 should always have on her gait belt when the client is in her wheelchair to support transfers and ambulation if the client gets out of her wheelchair. Continued interview with the QIDP verified client #1 has had a history of falls with a recent health decline that has resulted in why client #1 is currently using a wheelchair.

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W 227	Continued From page 7 Subsequent interview with the QIDP verified client #1 is a (2) staff transfer and client #1 should have guidelines to address transfers although no guidelines had been developed.	W 227		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure that opportunities for client choice and self-management were offered relative to activity choice and community integration for 4 of 4 clients (#1 #2, #3 and #4). The finding is: Observations in the group home on 8/18/21 from 7:55 AM to 10:00 AM revealed staff to secure clients #2 and #4 in the facility van to prepare for transport to the vocational program. Continued observation revealed staff to assist client #3 into the facility van. Further observation revealed staff to attempt to secure client #1 in the facility van via wheelchair lift when staff identified client #1 did not have a seatbelt attached to her wheelchair. Observation then revealed staff to remove client #1 from the wheelchair van lift to address concerns relative to the client's wheelchair. Subsequent observation revealed staff to have difficulty securing the safety strap for client #3 across the client, requiring staff to unload client #3 from the facility van. Additional observation revealed nursing staff to arrive at the group home to attach a seatbelt to client #1's wheelchair. Client #1 was then observed to be loaded onto the facility van and	W 247		

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W 247	Continued From page 8 transferred from her wheelchair into a seat on the van. Ongoing observation revealed clients #1, #2, and #4 to leave the group home while client #3 was assisted back into the group home unable to be transported due to issues with the safety strap of the van. At no point during the approximate 2 hour observation period were clients offered the opportunity to remain in the group home with leisure or program engagement until it was time to be transported to the vocational program. Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that clients should not have remained on the van for over an hour and a half while staff addressed seatbelt issues of client #1 and #3. The QIDP further confirmed that all clients should have been provided the opportunity for choice and self-management with regard to staying on the facility van as staff addressed concerns relative to client #1's wheelchair and client #3's safety strap.	W 247		
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, record review and	W 249		

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interview, the facility failed to ensure 1 of 3 sampled clients (#4) received a continuous active treatment program consisting of needed interventions as identified in the person centered plan (PCP). The finding is:

Afternoon observations in the group home on 8/17/21 from 4:30 PM to 5:30 PM revealed client #4 to participate in various activities such as prepare for and participate in the dinner meal. Further observations revealed client #4 to exhibit numerous behaviors throughout the observation period such as crawling on the floor, going into others' rooms, tantrum behaviors and throwing objects at staff and peers. Observations at 5:25 PM revealed staff E to assist client #4 onto the facility van for a van ride due to escalating behaviors. At no point during the observation period was client #4 offered a transition schedule, pictures or hand-held objects to help the client transition to various activities or to assist with escalating behaviors.

Morning observations in the group home on 8/17/21 from 6:30 AM to 8:45 AM revealed client #4 to participate in various activities such as grooming and to participate in the breakfast meal. Further observations revealed client #4 to exhibit numerous behaviors such as crawling on the floor, going into others' rooms, leaving her supervised area and tantrum behaviors. Continued observations revealed staff D to escort client #4 to the facility van and secure the client in the seat to prepare for the transition to the day program. At no point during the observation period was client #4 offered hand held objects, picture cues or a transition schedule to aid in de-escalating behaviors.

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W 249	Continued From page 10 Review of the record for client #4 on 8/18/21 revealed a person centered plan (PCP) dated 5/21/21 which included the following programs: to use a TEACCH object schedule, tolerate daily routine and follow the client's assigned schedule. Further review of the record revealed a behavior support plan (BSP) dated 6/2/21 which indicated staff should use objects, pictures and words to assist client #4 with transitions. Staff should also carry the objects and pictures in an apron. Review of the BSP also indicated that staff should offer hand held items to client #4 when agitated and to allow for appropriate sensory input. Staff should also use a zone schedule to keep client #4 safe and signs should be used to mark areas that client #4 is not allowed into. Review of the communication evaluation dated 5/2/21 indicated that client #4 requires a TEACCH schedule during transitions. Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that staff should have utilized a combination of the TEACCH object schedule, pictures and/or words to assist client #4 with transitions and deescalating behaviors. Further interview with the QIDP verified that all of client #4's programs and interventions are current. Continued interview with the QIDP confirmed that staff should use client #4's training objectives as prescribed to maintain structure, decrease target behaviors and aid in transition between activities.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience	W 287		

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W 287	Continued From page 11 of staff. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure a restrictive technique to manage inappropriate behavior was not used for the convenience of staff for 4 of 4 clients (#1, #2, #3 and #4). The finding is: Observations in the group home revealed the group home to have (2) locked closets with leisure items that included games and books. Continued observation revealed (1) leisure closet to have a personalized sign on the door that read "Client #4's leisure closet". Further observation throughout the 8/17-18/21 survey observations revealed at no time were the leisure closets used or unlocked for client use. Review of records on 8/18/21 for clients #1, #2, #3 and #4 revealed current habilitation plans with no restriction of implementing a lock on leisure closets or the restricted use of leisure items. Further review of the record for clients #1, #2, #3 and #4 did not reveal consents relative to the restricted use of leisure closets. Interview with staff E on 8/17/21 verified the leisure closets of the group home stay locked as client #1 and #4 will get into the closets and "mess with" items in each closet. Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified leisure items should be offered to all clients and used with client #4 to support redirection with behavior management. The facility QIDP confirmed there had been no identified need to have either leisure closet locked.	W 287		

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W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adaptive equipment was furnished or used in accordance with client needs for 2 of 4 sampled clients (#1 and #2). The findings are: A. The facility failed to ensure the wheelchair for client #1 had a seatbelt or footrests to support the safety of the client. The finding is: Observations of client #1 throughout the 8/17-18/21 survey revealed client #1 to move around the group home with a manual wheelchair. Observation on 8/18/21 at 7:07 AM revealed client #1 to sit at the kitchen table in her wheelchair with no seatbelt or foot rests. Observation of client #1's wheelchair revealed the left seatbelt strap to hang to the back of the client's wheelchair and the right strap to be missing. Subsequent observation of client #1 throughout the morning of 8/18/21 revealed client #1's feet to protrude out and to hit various door frames as the client was assisted with propelling into different areas of the group home. Observation at the group home on 8/18/21 at 8:35 AM revealed all clients to exit the group	W 436		

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home to begin loading the facility van for transport to the vocational program. Continued observation revealed staff C and staff F to assist client #1 with loading the van lift until interview by the surveyor verified client #1 did not have seat belt for her wheelchair. Further observation revealed staff C to remove client #1 from the van lift and to report client #1 was unable to use the van lift without a seatbelt due to safety concerns. Subsequent observation revealed nursing staff to visit the group home and to add a seatbelt to client #1's wheelchair that allowed client #1 to use the van lift to get onto the facility van. Additional observation throughout the process of client #1 loading the facility van revealed no footrests to be used on the wheelchair.

Review of records for client #1 on 8/18/21 revealed a current person centered plan (PCP) dated 12/17/20. Continued review of records for client #1 revealed a nursing note dated 12/30/20 that revealed client #1 was sent to the local emergency room after a behavior; diagnosed with a pelvic fracture and referred to Ortho Carolina for follow up. Further review of nursing notes revealed on 12/30/20 client #1 is using a wheelchair and (2) person assist from wheelchair to toilet and bed. Subsequent record review for client #1 revealed a mini-team report dated 4/7/21 that revealed the team met to discuss client #1's current situation; Ability to walk has decompensated since she has been required to be wheelchair bound with no weight bearing since pelvic fracture. Client #1 continues to remove her seatbelt and stand, slides out of wheelchair putting herself at serious risk of fracturing a bone.

Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G248	A. BUILDING _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLINGSWOOD GROUP HOME	214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677

(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
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should have a seatbelt on when sitting in her wheelchair due to a risk of falls. Continued interview with the QIDP verified client #1 should be using footrests on her wheelchair when loading the van or going out into the community to support safety of the client with positioning of her feet. Interview with the QIDP further revealed footrests for client #1 had been furnished and she was unsure why they had not been used during the survey period.

B. The facility failed to ensure adaptive equipment for client #2 was used as prescribed. For example:

Observations throughout the 8/17-18/21 survey revealed client #2 to wear bi-lateral AFO's and to ambulate with the use of a quad cane. Continued observations in the group home on 8/17/21 and 8/18/21 revealed at no time did client #2 wear glasses, arm brace, hand splint or to hold a rolled wash cloth to address contractures.

Review of records for client #2 on 8/18/21 revealed a PCP dated 7/9/21. A review of the current PCP revealed a diagnosis history of moderate intellectual disability, intermittent explosive disorder and cerebral palsy with adaptive equipment needs for client #2 to include a brace on arm during awake hours, bilateral AFO's during awake hours, a quad cane as needed and a wheelchair for extended outings. A review of an occupational therapy (OT) assessment for client #2 dated 8/3/20 revealed a left elbow splint is needed to prevent further contractures 2 times daily, 2 hours each day. Continued review of the OT evaluation revealed a left hand, comfy adjust splint is needed 2 times daily, 2-3 hours each day with additional

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	34G248	A. BUILDING _____ B. WING _____	08/18/2021

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recommendation that the client keeps a rolled up washcloth in her hand during waking hours. Subsequent record review revealed client #2 wears a brace on her arm during the day.

Additional review of records for client #2 on 8/18/21 revealed a vision consult dated 12/29/20. Review of the current vision consult revealed a diagnosis of glaucoma, myopia and astigmatism; prescription for glasses provided.

Interview with the QIDP on 8/18/21 revealed client #2 has an arm brace and should be wearing the brace as prescribed. Continued interview with the QIDP and facility nurse on 8/18/21 verified it was unknown where client #2's arm brace was located as it could not be found in the nursing office and staff were unable to locate it on the current survey date. Further interview with the QIDP verified client #2 has a hand splint and when client #2 is not wearing the hand splint, the client should be holding a rolled up washcloth in her left hand.

Interview with the facility nurse on 8/18/21 verified client #2 was furnished glasses and should be wearing her eyeglasses as prescribed. Continued interview with the facility nurse revealed client #2 had reported her glasses were broken (on the current survey date) although this was not verified and it was unknown where client #2's glasses were located or the current condition of the eyeglasses.