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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-994	A. BUILDING: _____ B. WING _____	R 10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE III, LLC/HICKORY TREE HOME	4010 HICKORY TREE LANE GREENSBORO, NC 27406

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on 10/15/21. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held at least quarterly and repeated for each shift. The findings are: Review on 10/14/21 and on 10/15/21 of the facility's fire drill log from 10/15/20-10/4/21 revealed: - No evidence a fire drill was held on third shift during the fourth quarter of 2020 (October -	V 114	A schedule has been created for all staff to follow to ensure all staff are completing fire/disaster drills in rotation month to month.	10/22/21

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

Brittney Haynes NSW QP 10-22-21

STATE FORM 6899 97111 If continuation sheet 1 of 15

Tag 114

1. What measures will be put in place to correct deficient area of practice ?

Staff will be receiving Inservice on fire and disaster drills.

2. What measures will be put in place to prevent the problem from occurring again ?

A schedule has been created for all staff to follow to ensure all shifts are completing fire and disaster drills in rotation month to month.

3. Who will monitor the situation to ensure it will not occur again ?

Home managers and Qp will be responsible for ensuring the fire and disaster drills are completed in rotation month to month.

4. How often the monitoring will take place ?

Home manager and Qp will monitor on a monthly basis.

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V 114	Continued From page 1 December) - No evidence a fire drill was held on first shift during the first quarter of 2021 (January - March) - No evidence a fire drill was held on second or third shift during the second quarter of 2021 (April - June) - No evidence a fire drill was held on second or third shift during the third quarter of 2021 (July - September) Review on 10/14/21 and on 10/15/21 of the facility's disaster drill log from 10/15/20-9/1/21 revealed: - No evidence a disaster drill was held on third shift during the fourth quarter of 2020 (October - December) - No evidence a disaster drill was held on second or third shift during the first quarter of 2021 (January - March) - No evidence a disaster drill was held on second or third shift during the second quarter of 2021 (April - June) - No evidence a disaster drill was held on first shift during the third quarter of 2021 (July - September) Interview on 10/14/21 with staff (#1 and #2) revealed: - Fire and disaster drills were held at least monthly and on a different shift. Interview on 10/15/21 with the Qualified Professional (QP) revealed: - The facility's shifts were as follows: 8 am until 4 pm (first shift); 2nd shift 4 pm - 12 am (second shift) and 12 am - 8 am (third shift) - Going forward, she would ensure staff conducted fire and disaster drills on a monthly basis and they were held on a different shift each month.	V 114	Home Managers and QP will monitor on a monthly basis.	

Tag 118-Recite

1. What measures will be put in place to correct deficient area of practice ?

Staff will be receiving Inservice on Medication Administration

2. What measures will be put in place to prevent the problem from occurring again ?

Night Shift will be responsible for checking all Meds and ensuring that meds were given and signed off on the Medication Administration Record.

3. Who will monitor the situation to ensure it will not occur again ?

Home manager and QP will be responsible for monitoring the Medication and Medication Administration Records.

4. How often the monitoring will take place ?

Home managers and Qp will be responsible for checking Medication Administration Records on a weekly basis.

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V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by:	V 118		

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V 118	Continued From page 3 Based on record review, observation and interview, the facility failed to ensure a Medication Administration Record (MAR) was kept current and medications administered were recorded immediately after administration affecting 2 of 3 audited clients (#2 and #3) The findings are: Finding #1: Review on 10/14/21 of client #2's record revealed: - An admission date of 5/15/18 - Diagnoses of Autistic Disorder (D/O); Moderate Intellectual Disability and Schizophrenia Observation on 10/15/21 of client #2's medications at 10:15 am revealed: - His medications included but were not limited to the following: Montelukast 10 mg 1 tab PO (by mouth) every night at bedtime; Olanzapine 20 mg 1 tab PO at bedtime and Melatonin 5 mg 1 tab PO daily at bedtime - Client #2's medications were in a "bubble pack" and the date and time listed on the back of the individual "bubble pack" to indicate when the what the medications were and when they were to be administered Review on 10/15/21 of client #2's September 2021 MAR revealed: - Documentation which reflected staff had administered client #2 Montelukast on 9/1-9/3 only - Documentation which reflected staff had administered client #2 Olanzapine on 9/1-9/2 and on 9/13 only - Documentation which reflected staff had administered client #2 Melatonin on 9/1; 9/11-9/12 and on 9/27 only	V 118		

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V 118	Continued From page 4 Finding #2: Review on 10/14/21 of client #3's record revealed: - An admission date of 2/17/17 - A diagnosis of Traumatic Brain Injury - Client #3 had been prescribed Myrbetriq 50 mg 1 tab PO daily on 8/16/21 Observation on 10/15/21 of client #3's medications at 10:35 am revealed: - Myrbetriq 50 mg 1 tab PO daily - Client #3's medications were in a "bubble pack" and had the date and time listed on the back of the individual "bubble pack" to indicate what the medications were and when they were to be administered Review on 10/15/21 of client #3's MARs from 8/1/21-10/15/21 revealed: - Myrbetriq was not listed on client #3's September 2021 MAR Continued review of client #3's record on 10/15/21 revealed: - No written physician's order to discontinue Myrbetriq 50 mg for the month of September 2021 Interviews on 10/15/21 with clients (#2 and #3) revealed: - Staff administered their medications to them on a daily basis Interview on 10/15/21 with the Qualified Professional revealed: - The clients' medications were packaged in an individual "bubble pack" so staff knew what medications the clients were to receive and when	V 118		

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V 118	Continued From page 5 - She had no explanation as to why staff had not documented when they administered client #2 his medications as prescribed or why Myrbetriq was not listed on client #3's September MAR - She planned to review the September MAR to determine which staff had failed to properly document when they had administered client #2 his medications and there would be disciplinary action taken - She also planned to schedule a training on MARs and visit the facility during the times when medications were to be administered by staff. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to the date of hire affecting 1 of 3 audited staff (staff #1). The findings are:	V 131	Health Care personnel Registry (HCPR) prior to date of hire for all staff will be placed back into personnel files.	10/22/21

Tag 131

1. What measures will be put in place to correct deficient area of practice ?

Health Care Registry Prior to date of hire will be pulled from back up files and returned to the staff files.

2. What measures will be put in place to prevent the problem from occurring again ?

Health Care Registry's prior to date of hire will remain in staff files.

3. Who will monitor the situation to ensure it will not occur again ?

Qp will be responsible for monitoring the staff files to ensure old and current Health Care Registry remains in the file.

4. How often the monitoring will take place ?

Qp will maintain Health Care Registry's annually.

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V 131	Continued From page 6 Review on 10/14/21 of staff #1's record revealed: - A date of hire of 6/23/20 - The HCPR was accessed on 6/22/21 - No evidence the HCPR had been accessed on behalf of staff #1 in 2020 Interview on 10/15/21 with the Qualified Professional revealed: - The HCPR was accessed on a yearly basis for each staff - She felt certain the HCPR had been accessed on behalf of staff #1 in 2020; however, the information must have been purged from his record.	V 131	Prior HCPR will be placed back into the file Will ensure staff files maintain HCPR prior to hire Qualified professional will maintain HCPR annually	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based,	V 536	Staff #1 completed the training in Alternative to Restrictive Interventions (NCI). A copy of the certification has been placed in the staff's file. Training will be monitored quarterly to avoid future lapse.	

Tag 536

1. What measures will be put in place to correct deficient area of practice ?

Staff #1 completed training in Alternative to Restrictive Interventions (NCI). A copy of the certification has been placed in the staff's file.

2. What measures will be put in place to prevent the problem from occurring again ?

Qp will create a spreadsheet to better upkeep trainings.

3. Who will monitor the situation to ensure it will not occur again ?

Qp will monitor trainings.

4. How often the monitoring will take place ?

Qp will monitor trainings on a monthly basis.

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V 536	Continued From page 7 include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain	V 536		

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V 536	Continued From page 8 documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive	V 536		

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V 536	Continued From page 9 interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff had formal refresher training at least annually in the use of alternatives to	V 536		

Tag 537

1. **What measures will be put in place to correct deficient area of practice ?**

Staff #1 completed the training in seclusion, physical restraint, and isolation Time-Out (NCI). A copy of the certification has been placed in the staff's file.

2. **What measures will be put in place to prevent the problem from occurring again ?**

Qp will create a spreadsheet to better upkeep trainings.

3. **Who will monitor the situation to ensure it will not occur again ?**

Qp will monitor trainings

4. **How often the monitoring will take place ?**

Qp will monitor trainings on a monthly basis

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V 536	Continued From page 10 restrictive interventions for 1 of 3 audited staff (staff #1). The findings are: Review on 10/14/21 of staff #1's record revealed: - A date of hire of 6/23/20 - Staff #1's training in alternatives to restrictive interventions expired on 6/29/21 Interview on 10/14/21 with staff #1 revealed: - He believed he was current in all of his training. Interview on 10/14/21 with the Qualified Professional revealed: - Due to the COVID-19 pandemic, it had been difficult to schedule in-person trainings in a timely manner - Staff #1 was scheduled to complete his annual refresher training in the use of alternatives to restrictive interventions on 10/20/21.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or	V 537	Staff #1 completed the training in Seclusion, Physical Restraint and Isolation Time-Out (NCI). A copy of the training has been placed in staff #1 file.	10/22/21

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V 537	Continued From page 11 volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe	V 537		

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	MHL041-994	A. BUILDING: _____ B. WING _____	R 10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE III, LLC/HICKORY TREE HOME	4010 HICKORY TREE LANE GREENSBORO, NC 27406

(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) COMPLETE DATE
V 537	Continued From page 12 use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.	V 537		

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V 537	Continued From page 13 (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached.	V 537		

Division of Health Service Regulation

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FORM APPROVED

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V 537	Continued From page 14 (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff had formal refresher training at least annually in the use of seclusion, physical restraint and isolation time-out for 1 of 3 audited staff (staff #1) The findings are: Review on 10/14/21 of staff #1's record revealed: - A date of hire of 6/23/20 - Staff #1's training in seclusion, physical restraint and isolation time-out expired on 6/29/21 Interview on 10/14/21 with staff #1 revealed: - He believed he was current in all of his trainings - He had not had to use a physical restraint on any of the clients since being hired. Interview on 10/14/21 with the Qualified Professional revealed: - Due to the COVID-19 pandemic, it had been difficult to schedule in person trainings in a timely manner - Staff #1 was scheduled to complete his annual refresher training in seclusion, physical restraint and isolation time-out on 10/20/21.	V 537		

Quality Care III

FACSIMILE TRANSMITTAL

To: Debra M. Branton	**Fax #: 919-715-8078**
From: Quality Care III	**Fax #: 336-370-6457**
Pages:	**Date:**
Re:	