Division	of Health Service Re	egulation			OMMERICATO
	IT OF DEFICIENCIES OF CORRECTION	(X1) PRÓVIDER/SUPPLIER/CLIA IDEN DRÍCA DON NOMBER:			(X3) DATE SURVEY
		MHL041-994	B. WING		R 10/15/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	
QUALITY	CARE III, LLC/HICK	DRY IRPH HOME	KORY TREE		
(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 APPRO DEFICIENCY)	LD BE COMPLETE
V 000	INITIAL COMMEN	rs	V 000		
·	An annual and follo on 10/15/21. Defici	w up survey was completed encies were cited.			
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.			
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114		
	AND SUPPLIES	07 EMERGENCY PLANS			
	area-wide disaster	n for each facility and plan shall be developed and by the appropriate local			
	(b) The plan shall b	e made available to all staff cedures and routes shall be			
	(c) Fire and disaste shall be held at least	r drills in a 24-hour facility at quarterly and shall be			
ļ	under conditions the	hift. Drills shall be conducted at simulate fire emergencies. Il have basic first aid supplies			
				a adoptula lors he	Les 1/22/20
	This Rule is not me Based on record re	view and interview, the facility		created for all Sta	ff
	failed to ensure fire	and disaster drills were held disaster for each shift.		A schedule has be created for all sta to fo 110 mb to ensure all staff are comfire/disaster drills i rotation month to m	pleting
	Review on 10/14/21	and on 10/15/21 of the from 10/15/20-10/4/21		fire/disaster drills 1	owth.
	revealed: - No evidence a t	ire drill was held on third shift		rotation month	
) Vivision of He	alth Service Regulation	arter of 2020 (October -		<u> </u>	
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE /	TITLE	(X6) DATE

STATE FORM

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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PRINTED: 10/18/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ 8. WING MHL041-994 10/15/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4010 HICKORY TREE LANE** QUALITY CARE III, LLC/HICKORY TREE HOME GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 1 Home managers and QP will manifor on a monthly basis, V 114 V 114 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 guarter 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. Division of Health Service Regulation

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.

Division	of Health Service R	egulation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or constantly	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		MHL041-994	B. WING		1	R 15/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE		
QUALIT	Y CARE III, LLC/HICK	ORY TREE HOME 4010 HIC	KORY TREE	LANE		
(X4) ID	SUMMARY STA	ATEMENT OF DEPICIENCIES	T io	PROVIDER'S PLAN OF CORRECTION	3NI	n.
PRÉFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	10A NCAC 27G .02 REQUIREMENTS	209 MEDICATION				***************************************
	(c) Medication adm	inistration:				***************************************
	(1) Prescription or r	10n-prescription drugs shall				
	order of a person a	d to a client on the written uthorized by law to prescribe				
	arugs.	·				
,	(2) Medications sha clients only when at	ill be self-administered by uthorized in writing by the				
	client's physician.		***************************************	•		The state of the s
	administered only b	luding injections, shall be y licensed persons, or by	A CONTRACTOR OF THE CONTRACTOR			es-d-d-
	unlicensed persons	trained by a registered nurse	***			Potential Processor
	pnarmacist or other privileged to prepare	legally qualified person and and administer medications.				
	(4) A Wedication Adi	ministration Record (MAR) of				
	all drugs administer current. Medications	ed to each client must be kept administered shall be			,	
	recorded immediate	ly after administration. The	***************************************			
	MAR is to include th (A) client's name:	e following:	MANAGEMENT A. C. COMMANDER		**************************************	
	(B) name, strength,	and quantity of the drug;	Week the second			
1	(C) instructions for a	idministering the drug.				
	(E) name or initials of	e drug is administered; and of person administering the			***************************************	
] (arug.	~	***************************************			
	checks shall be reco	or medication changes or orded and kept with the MAR			***************************************	
1	riie tollowed up by ap	ppointment or consultation			***************************************	
] '	with a physician.	}	-			
	•		-			
			-			
I	This Rule is not met	as evidenced by:	***************************************		1	
rision of Hea	Ith Service Regulation					

Division	of Health Service Re	egulation			FORM	IAPPROVED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	STATE, ZIP CODE		10/404
QUALIT	Y CARE III, LLC/HICK	45.44.1	KORY TREE			
		GREENS	BORO, NC 2	7406		
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V 118	Continued From pa	ge 3	V 118			
	Interview the facility Administration Reci and medications ad immediately after a audited clients (#2 a Finding #1:	view, observation and y failed to ensure a Medication ord (MAR) was kept current iministered were recorded dministration affecting 2 of 3 and #3) The findings are:				
	Review on 10/14/21 revealed:	of client #2's record				**************************************
	An admission dDiagnoses of Ar	ate of 5/15/18 utistic Disorder (D/O); al Disability and Schizophrenia				Vertebro- versoni rozavoja rozavlja
	to the following: Mor mouth) every night a 1 tab PO at bedtime PO daily at bedtime - Client #2's medi pack" and the date a the individual "bubbl	15/21 of client #2's 5 am revealed: 5 included but were not limited ntelukast 10 mg 1 tab PO (by at bedtime; Olanzapine 20 mg and Melatonin 5 mg 1 tab cations were in a "bubble and time listed on the back of e pack" to indicate when the s were and when they were				
	2021 MAR revealed: - Documentation value administered client # only - Documentation value administered client # on 9/13 only - Documentation value administered client # on 9/13 only	of client #2's September which reflected staff had '2 Montelukast on 9/1-9/3 which reflected staff had '2 Olanzapine on 9/1-9/2 and which reflected staff had 2 Melatonin on 9/1; 9/11-9/12				
vision of Hea ATE FORM	ilth Service Regulation					

Divisio	<u>n of Health Service F</u>	Regulation			FORM	MAPPROVE
STATEMI AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	STATE, ZIP CODE		30,202
QUALIT	TY CARE III, LLC/HICK		KORY TREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE	(X5) COMPLETE CATE
V 118	Continued From pa	age 4	V 118			
	Finding #2:	~				
	Review on 10/14/2 revealed: - An admission of A diagnosis of Client #3 had b mg 1 tab PO daily of Client #3 medications at 10:3 - Myrbetriq 50 mg Client #3's med pack" and had the oback of the individual	Fraumatic Brain Injury een prescribed Myrbetriq 50 on 8/16/21 15/21 of client #3's			·	
	- Myrbetriq was not September 2021 MA Continued review of 10/15/21 revealed: - No written physical Myrbetriq 50 mg for 12021 Interviews on 10/15/21 revealed: - Staff administered on a daily basis Interview on 10/15/21 revealed: - The clients' medical control of the control of the clients' medical control of the c	ot listed on client #3's AR client #3's record on clients order to discontinue the month of September 21 with clients (#2 and #3) and their medications to them				
sion of Hea	ilth Service Regulation	ts were to receive and when				
TE FORM	······································					

PRINTED: 10/18/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL041-994 10/15/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4010 HICKORY TREE LANE QUALITY CARE III, LLC/HICKORY TREE HOME GREENSBORO, NC 27406 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) V 118 Continued From page 5 V 118 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 131 G.S. 131E-256 (D2) HCPR - Prior Employment V 131 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. Health Care Herr) 10/22/21

Personnel Registry (Herr) 10/22/21

Personnel Registry (Herr) 10/22/21

Personnel files

back into personnel 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: Division of Health Service Regulation STATE FORM

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?

Op will maintain Health Care Registry's annually.

Division	of Health Service R	egulation			FORM APPROVE
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
		MHL041-994	B. WING		R 10/15/2021
	PROVIDER OR SUPPLIER Y CARE III, LLC/HICK	ORY TREE HOME 4010 HIC	DORESS, CITY, KORY TREE BORO, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DRF COMPLETE
V 131	Continued From pa	age 6	V 131		
	- A date of hire of The HCPR was - No evidence the on behalf of staff #- Interview on 10/15/. Professional reveal - The HCPR was for each staff - She felt certain accessed on behalf the information must record. 27E .0107 Client Right. 10A NCAC 27E .010 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall in practices that emphato restrictive interver (b) Prior to providing disabilities, staff include employees, students demonstrate compete completing training in other strategies for owhich the likelihood or injury to a person property damage is property damage is properly damage and demonstrate competence and demonstrate competence of the strategies for control of the strategies for cont	e HCPR had been accessed in 2020 21 with the Qualified ed: c accessed on a yearly basis the HCPR had been of staff #1 in 2020; however, of have been purged from his ghts - Training on Alt to Rest. 7 TRAINING ON 0 RESTRICTIVE Inplement policies and asize the use of alternatives intions. It is services to people with uding service providers, is or volunteers, shall tence by successfully in communication skills and creating an environment in of imminent danger of abuse with disabilities or others or	V 536	Prior HCPR Will be Placed back puto the file Will ensure staff Vile & main tain the prior to hire outlined professional win maintain there annua maintain there annua raining in Alternative training in Alternative restrictive Intervention Restrictive Intervention Restrictive Intervention Certification has be Certification the will Pile. Training wonitored quarterly monitored future lapse. a void future lapse.	IPR Illy he hos
vision of Hea ATE FORM	Ith Service Regulation	. Ass	4		

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?

 On will create a spreadsheet to better upkeep trainings.
- 3. Who will monitor the situation to ensure it will not occur again?

 Op will monitor trainings.
- 4. How often the monitoring will take place?

Op will monitor trainings on a monthly basis.

UNALLIA CARE ILL

<u>@</u>0013/0021

Division	of Health Service R	egulation			1 (1/14)	MERKUVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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		MHL041-994	B. WING			5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY	, STATE, ZIP CODE		
QUALITY	CARE III, LLC/HICK	L.22CT (2CCCCC PER 2ER 2DM)**	KORY TRE			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	BORO, NC	PROVIDER'S PLAN OF CORRECTI	/Nt	/AV#\
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V 536	Continued From pa	ige 7	V 536			·
	include measurable measurable testing behavior) on those methods to determicourse. (e) Formal refreshe by each service proannually). (f) Content of the transport of the Division of MH/I Paragraph (g) of this (g) Staff shall demonstrate of the Division of MH/I Paragraph (g) of this (g) Staff shall demonstrate of the Division of MH/I Paragraph (g) of this (g) Staff shall demonstrate of the Division of MH/I Paragraph (g) recognizing the people being server (2) recognizing external stressors the disabilities; (d) recognizing external stressors the disabilities; (d) strategies relationships with personal factor disabilities; (d) recognizing organizational factor disabilities; (e) recognizing assisting in the personal decisions about their decisions about thei	e learning objectives, (written and by observation of objectives and measurable ine passing or failing the er training must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to is Rule. Constrate competence in the service end understanding of the digram of the effect of internal and hat may affect people with for building positive ersons with disabilities; and cultural, environmental and rest that may affect people with go the importance of and con's involvement in making in life; assessing individual risk for eation strategies for defusing otentially dangerous behavior; chavioral supports (providing ith disabilities to choose otly oppose or replace unsafe).				
	alth Service Regulation	<u></u>			-	
TATE FORM	-	•	5899	971111	If continuatio	n sheet 8 of 15

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
AND FEAT	OF CONNECTION	IDENTIFICATION NUMBER;	A. BUILDING	***************************************	COMF	LETED
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	,	MHL041-994	B. WING			5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AN	hopes any	STATE, ZIP CODE	,	
		4040 1110	KORY TREE			
QUALITY	CARE III, LLC/HICK	URT IRCE MINNE	BORO, NC 2			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	Ţ		***	T
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 8	V 536			
	documentation of ir at least three years (1) Documen (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divising review/request this (i) Instructor Qualif Requirements: (1) Trainers a by scoring 100% on aimed at preventing need for restrictive if (2) Trainers a by scoring a passing instructor training properties (3) The training competency-based, objectives, measural observation of behameasurable method failing the course.	nitial and refresher training for tation shall include: sipated in the training and the li); I where they attended; and is name; ion of MH/DD/SAS may documentation at any time. Ications and Training shall demonstrate competence intesting in a training program producing and eliminating the interventions. In the interventions in an arrogram. In the include measurable learning able testing (written and by vior) on those objectives and is to determine passing or	V 536			
	service provider plan approved by the Div to Subparagraph (i)(nt of the instructor training the ns to employ shall be ision of MH/DD/SAS pursuant (5) of this Rule.				
	shall include but are (A) understand	e instructor training programs not limited to presentation of: ding the adult learner;	Commonwe againments in a common commo			
	course; (C) methods f	or teaching content of the or evaluating trainee	Comments of the Comments of th			
	(6) Trainers st teaching a training p	ntion procedures. nall have coached experience rogram aimed at preventing, ating the need for restrictive		,		
ivision of He	alth Service Regulation			***************************************		

I D MANO	E SURVEY PLETED	(X3) DATE COMP	E CONSTRUCTION	1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NT OF DEFICIENCIES N OF CORRECTION	
ANME OF PROVIDER OR SUPPLIER GUALITY CARE III, LLC/HICKORY TREE HOME GREENSBORO, NC 27406 (A4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 for at least three years. (1) Service providers shall maintain documentation of initial and refresher instructors (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/I/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall teach of coaching or train-the-trainer instruction. (I) Documentation of coaching or train-the-trainer instruction. (I) Documentation of coaching or train-the-trainer instruction. (I) Documentation of coaching or train-the-trainer instruction.	R 15/2021			B. WING	MHL041-994		
SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION SHOULD BE PREFIX TAG			LANE	KORY TREE	ORY TREE HOME 4010 HICH		
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	(X5) COMPLETE DATE	N SHOULD BE EAPPROPRIATE	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	ID PREFIX	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PRÉFIX
This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff had formal refresher training				V 536	st one time, with positive chall teach a training program control reducing and eliminating the complete a refresher complete complete complete a refresher complete complete a refresher complete complete a refresher complete complete a refresher complete comple	interventions at lease review by the coach (7) Trainers is aimed at preventing need for restrictive annually. (8) Trainers instructor training at (j) Service provider documentation of intraining for at least to (1) Documentation of intraining for at least to (1) Documentation of intraining for at least to (1) Documentation (2) The Division outcomes (pass/fail) (B) when and (C) instructor (2) The Division request and review to (k) Qualifications of (1) Coaches is requirements as a troin train-the-trainer instroining (i) Documentation in sa for trainers. This Rule is not met Based on record reviews the coaches are competence by competence	
at least annually in the use of alternatives to ivision of Health Service Regulation TATE FORM		If continuation s		i	ne use of alternatives to	at least annually in the alth Service Regulation	vision of Hea

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 ?

Op 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?

Op will monitor trainings on a monthly basis

Division of H	<u>feaith Service R</u>	egulation	1		FOR	D: 10/18/20 MAPPROVI
AND PLAN OF C	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG:	(X3) DAT	E SURVEY
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QUALITY CA	RE III, LLC/HICKI	ORY TREE HOME 4010 HIS GREEN:	CKORY TRE SBORO, NO	E LANE 27406		
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V 536 Cor	ntinued From pag	ge 10	V 536	DEFICIENCY)		
rest		Ons for 1 of 3 audited state	030			**************************************
-	wate of tile of	of staff #1's record revealed; 6/23/20	3			And the second s
[,	Staff #1's trainin ventions expired	o in alternatives to restriction				MANAGE CONTRACTOR OF THE STATE
Inter - I train	he believed be A	1 with staff #1 revealed: vas current in all of his				
) FIOIE	Ssional revealed	1 with the Qualified d:				
manr	jer Jer	D-19 pandemic, it had been n-person trainings in a timely	,			
្រារប	ai ieilesner frain	eduled to complete his ing in the use of alternatives ions on 10/20/21.	``````````````````````````````````````			
V 537 27E .	0108 Client Righ	its - Training in Sec Rest &	V 537	Staff # 1 completed +	he	1927/21
SECL ISOLA	1110N 11ME-00	CAL RESTRAINT AND	, , , , , , , , , , , , , , , , , , ,	Restraint and Isolation	o of	
(a) Se time-o been t compe	eclusion, physica out may be emplorations rained and have etence in the pro-	al restraint and isolation byed only by staff who have demonstrated	*	Statt # 1 Compresed + training in Seclusion, Pl Restraint and Isolation Time-Out (NCI). A copy the training has been placed in staff # 1 file	60 2.	
staff a	uthorized to emplores are retrain.	racilities shall ensure that ploy and terminate these ed and have demonstrated		•		
(b) Pridisabili	ilies whose treat	rect care to people with	;			
# ICIDGE	s restrictive inte	rventions, staff including	£ .			
n of Health Serv						
FORM		88 3		***************************************	· · · · · · · · · · · · · · · · · · ·	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			PLE CONSTRUCTION G:		E SURVEY PLETED
				,			D
		MHL041-994		B. WING _			R 15/2021
NAME OF	PROVIDER OR SUPPLIER	STR	REETADD	RESS, CITY	, STATE, ZIP CODE		
QUALITY	CARE III, LLC/HICK	.765 T 155 C C 253 JIMIP		ORY TRE ORO, NC			
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	()	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 11		V 537			
	volunteers shall cor seclusion, physical and shall not use the training is complete demonstrated. (c) A pre-requisite of demonstrating complete demonstrating complete demonstrating complete demonstrating complete in the need for restrict (d) The training shall include measurable testing behavior) on those of methods to determine course. (e) Formal refreshed by each service provanually). (f) Content of the training shall include measurable testing behavior) on those of methods to determine course. (e) Formal refreshed by each service provanually). (f) Content of the training provider plans to emphasize of the use of restrictive (d) refresher in the use of restrictive (e) guidelines (understanding imminothers); (3) emphasise of concepts of least resincemental steps in (e) strategies in of restrictive interventions which in assessment and more interventions which in a second intervention in the second interventions which in a second intervention in the seco	implete training in the use restraint and isolation time ese interventions until the dand competence is for taking this training is petence by completion of g, reducing and eliminating its interventions. If be competency-based, learning objectives, (written and by observation of the passing or failing the extraining must be completed by the passing or failing the extraining must be completed by the periodically (minimus aining that the service oppoyment to grant to g	f ng on of ole eted um ey de, s to	V 537			
ivision of Un-	alth Service Regulation						
TATE FORM			6899		971111	if continuation	anan takke

Division STATEME	n of Health Service F	Regulation	<u>:</u>		PRINTE FOR	D: 10/18/202 MAPPROVE
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DAT	'E SURVEY MPLETED
		MHL041-994	B. WING			R
	PROVIDER OR SUPPLIER	O I KEE! W	DDRESS, CITY, S	TATE, ZIP CODE	10,	15/2021
QUALIT	Y CARE III, LLC/HICK	ORY TREE HOME 4010 HIC	KORY TREE	LANE		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DECISION	BORO, NC 2	The same of the sa		
TAG	- TOWN ORL	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE	(XS) COMPLETE DATE
V 537	Continued From pa	ge 12	V 537		•	
to the content of the	(6) prohibited (7) debriefing importance and pury (8) documents (h) Service providers documentation of initiat least three years. (1) Documents (A) who particing outcomes (pass/fail) (B) when and the contents (C) instructor's (C) The Division review/request this definition (i) Instructor Qualific Requirements: (1) Trainers shows scoring 100% on the content shows scoring 100% on the content shows scoring a passing of the training prospectives, measurably scoring a passing of the training content shows a property of the training content shows a property of the training content shows a property of the training of the training of the content shows a provider plans (b) The content shows a provider plans	procedures; strategies, including their pose; and ation methods/procedures. s shall maintain itial and refresher training for ation shall include: pated in the training and the where they attended; and in name. In of MH/DD/SAS may ocumentation at any time. ation and Training all demonstrate competence esting in a training program reducing and eliminating the terventions. all demonstrate competence esting in a training program reducing and realiminating the terventions. all demonstrate competence esting in a training program eclusion, physical restraint all demonstrate competence grade on testing in an gram. shall be clude measurable learning the testing (written and by or) on those objectives and to determine passing or of the instructor training the to employ shall be				
j di	oproved by the Division Subparagraph (j)(6)	on of MH/DD/SAS nureuses!	Ì			
		Vi ano ruie.	-			
i of Healt FORM	h Service Regulation		,			
		4000	97111	1	If Continuation of	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	PLE CONSTRUCTION 3:	(X3) DATE COMP	SURVEY LETED
					F	२
		MHL041-994	B. WING _		10/1	5/2021
	PROVIDER OR SUPPLIER Y CARE III, LLC/HICK(ORY TREE HOME 4010 HIC	KORY TRE		•	
	423.22.23.32.3		BORO, NC	27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 13	V 537			
	ehall include, but no of: (A) understand	e instructor training programs t be limited to, procentation ding the adult learner; for teaching content of the			ļ	
	course; (C) evaluation	or teaching content of the or of trainee performance; and ation procedures.				
	(7) Trainers s annually and demor	hall be retrained at least estrate competence in the use	**************************************	***************************************		
İ	time-out, as specifie Rule.	al restraint and isolation d in Paragraph (a) of this	or a secure of a second more			
	CPR.	hall be currently trained in	\$	To the state of th		
	in teaching the use	hall have coached experience of restrictive interventions at a positive review by the				
	use of restrictive into annually.	nall teach a program on the erventions at least once				
	instructor training at (k) Service provider	nall complete a refresher least every two years. s shall maintain			The state of the s	
	training for at least the (1) Document	ation shall include:	,			
	outcome (pass/fail);	pated in the training and the where they attended; and	,			
	(C) instructor's (2) The Division	s name. on of MH/DD/SAS may ocumentation at any time.	* * * * * * * * * * * * * * * * * * *			
	(I) Qualifications of (Doaches: hall meet all preparation	Annon N			
	(2) Coaches s	hall teach at least three ich is being coached.				
ivision of He TATE FORM	alth Service Regulation		, ,	971111	# configuration	obasi idase

	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II Tro	E COMPTOMOTICA		M APPRO
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING-		(X3) DATE SURVEY	
		MHL041-994				R
NAME OF PROVIDER OR SURBLES			8. WING		10/15/202	
		STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	CARE III, LLC/HICK	ORY TREE HOME 4070 HIG GREENS	KORY TREE	LANE		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OF LSC STATEMENT OF CORRECTION					
TAG		DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPI DAT
V 537	Continued From page	ge 14	V 537			
	(3) Coaches shall demonstrate		100			
	competence by completion of coaching or		***************************************			***************************************
	train-the-trainer instruction. (m) Documentation shall be the same					
	preparation as for tra	ainers.				
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	This Dulo is		,			
1 1	This Rule is not met Based on record revi	OM and into-decision to				
, ,	SHOW IN CHARGE STAIT	DOM formant	.			
} ***	'' '''' WWL WILLIUM 133 111	A HEA AT PARKET	,			
, ,	taff (staff #1) The fin					
F	Review on 10/14/21 o	of staff #1's record revealed:				
	Staff #1's training	in section in the sec				
ir tr	estraint and isolation	time-out expired on 6/29/21	:			
	terview on 10/14/21	with staff #1 revealed:				
	Lie believed be Ma	as current in all of his				
	D11111172	i				
	ny of the clients since	use a physical restraint on			Ì	
		1				
P	terview on 10/14/21 ofessional revealed:	with the Qualified				
-	Due to the COVID	-19 nandemic it had been	,			
dit	near to schedule in .	person trainings in a timely				
l m	#iii(다)	· · · · · · · · · · · · · · · · · · ·				
an	ingi i ell eguét (LSIVII)	duled to complete his ng in seclusion, physical			ſ	'
res	straint and isolation t	ime-out on 10/20/21,				
			,			
of Health	Service Regulation					



FACSIMILE TRANSMITTAL

To: Debra M. Branton		Fax #: 919-715-8078 Fax #: 336-370-6457				
From: Quality Care III						
Pages:		Date:				
Re:			and any or the second s			
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