PRINTED: 12/16/2021
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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
	MHL0411169	A. BUILDING: _____ B. WING _____	C 12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE III, LLC/BRIDFORD PLACE	1410 BRIDFORD PARKWAY, APT C GREENSBORO, NC 27407

(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 A complaint survey was completed on 12/7/21. One complaint was substantiated (intake #NC00183549) and one complaint was unsubstantiated (intake #NC00183568). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities. The survey sample consisted of audits of 2 former clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and	V 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brittan Davies MSW QP — TITLE — (X6) DATE: 12/23/21

RECEIVED
By DHSR Mental Health Licensure & Certification at 1:49 pm, Dec 29, 2021

Tag 110

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

Staff will be required to attend/ complete training

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

Qualified professional/associate professional will give a test based on competencies

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

Qualified professional and associate professional

How often will monitoring take place?

Monitoring will occur monthly

Tag 132

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

Clinical professional will investigate in a timely manner and submit allegations into the IRIS portal

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

Clinical professional will include any future allegations into the IRIS portal

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

Qualified Professional and Associate Professional

How often will monitoring take place?

Monitoring will occur monthly

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V 110	Continued From page 1 (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 audited paraprofessional (the Group Home Manager) failed to demonstrate the knowledge, skills and abilities required by the population being served. The findings are: Review on 11/29/21 of an incident report submitted by Qualified Professional #1 (QP #1) on 11/19/21 revealed: - On 11/17/21, "...after receiving a call regarding Thanksgiving visit [FC #1] became upset. The group home manager stated that he, the guardian and [family member] had been communicating with each other and the [family member] stopped when there was a transporting problem and began communicating with [FC #1]. [FC #1] felt the group home manager had cutoff the visit with the [family member] before any concrete plans were put in place. Prior to this incident, group home manager stated he reached out to the guardian and had a 3-way conversation with the [family member], guardian and himself. The guardian stated that it was ok with the visit and stated he just needed time and date. When the group home manager tried to redirect [FC #1's] behavior and explain that nothing was final at this point, he began to destroy the home,	V 110		

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V 110	Continued From page 2 cursing and physically attacking the manager..." Review on 11/29/21 of Former Client #1's record (FC #1's) revealed: - An admission date of 3/3/21 - Diagnoses: Autism Spectrum Disorder (D/O), Level I (High Functioning Autism); Attention Deficit Hyperactivity D/O, Combined; Oppositional Defiant D/O; Unspecified Depressive D/O; Intellectual Developmental Disability, Mild; Unspecified Trauma and Stress-Related D/O and Conduct D/O - A discharge date of 11/17/21 - FC #1 was 17 years old - A treatment plan dated 11/30/20 and last updated on 3/3/21 revealed: "Crisis Prevention and Intervention: "...Some triggers may be not having clear and consistent expectation...being told no...becoming fixated on staff when he feels they do not like him or are mistreating him..." - A Behavior Support Plan (BSP) completed by a Behavioral Support Specialist and dated 2/17/21 revealed: - "When access to preferred item/activity is denied, changes in routine occur, or demands are placed, [FC #1]will engage in maladaptive behaviors including physical aggression; self-injurious behavior; property destruction; elopement; program refusal, disruption; inappropriate verbal behavior; stealing, threats of self-harm and false reporting ..." An attempt to interview FC #1 on 12/1/21 was unsuccessful as the FC #1 had eloped from his new placement on 11/29/21 and his whereabouts were unknown. Review on 11/29/21 of the Group Home Manager's (GHM's) record revealed: - A hire date of 8/2/21 as a Paraprofessional	V 110		

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V 110	Continued From page 3 - A disciplinary action form completed by the Qualified Professional #1 (QP #1) and signed by the GHM on 11/18/21 which read as follows: "On November 17, 2021 it was brought to the attention of [name of the Licensee] there had been activities/communication going on between AFL provider/Group Home manager and the Legal Guardian of [FC #1's initials] and failure to communicate with the Agency of all communication involving the consumer [FC #1's initials]. Be advised that any further insubordination will result in disciplinary action, up to and including termination." Interview on 12/2/21 with the GHM revealed: - It was his idea to have FC #1 visit his family for Thanksgiving - He was "trying to be nice" and was working on behalf of FC #1 for him to see his family on Thanksgiving - FC #1's legal guardian had granted FC #1 permission to visit with a family member and he had been in communication with the legal guardian and the family member to work out the details - "[FC #1] was in the loop and knew about the plans." - He had also spoken with the QPs (#1 and #2) about a possible visit and they expressed no concerns to him regarding FC #1 visiting this particular family member - Although he, FC #1's legal guardian and the family member were working on the specifics of the visit, "Nothing was set in stone and no promises had been made." - On 11/17/21, while on the phone with the family member, she reported there were some issues with her being able to pick FC #1 up from the facility as well her being concerned she would not be able to handle FC #1 if he were act out	V 110		

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V 110	Continued From page 4 while visiting with her - "She didn't really want [FC #1] coming ...she was older and didn't feel she could handle" FC #1 - On the same date, (11/17/21), the family member texted FC #1 and told him he would not be able to come for a Thanksgiving visit and it was the GHM's fault - When FC #1 realized that he would not be able to visit his family, FC #1 became verbally and physically aggressive towards the GHM and began to destroy items in the facility - FC#1 broke the television in the living room, his video games, a fan, a window in his bedroom and kicked a hole in a door - He was just throwing, breaking stuff." - FC #1 also struck the GHM, leaving a mark on his neck - FC #1 had a "lot of built up anger." - When the GHM could not de-escalate the situation, he contacted the owner of the facility and the owner directed him to call the police - The police picked up FC #1 from the facility and transported him to a hospital for an evaluation because of his verbal/physical aggression and property destruction - He had received a disciplinary warning regarding the events of 11/17/21; however, he was unsure why - He believed everyone was fully aware of what he had been trying to do on behalf of FC #1 - "I was on his (FC #1's) side; my problem was I was too nice." Interviews on 11/29/21 with the QPs (#1 and #2) revealed: - They learned on 11/17/21 that FC #1 being unable to visit a family member for Thanksgiving had been what triggered his behavior on that same date - Prior to the events of 11/17/21, the GHM had	V 110		

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V 110	Continued From page 5 not spoken to either of them about FC #1 possibly visiting with family and that he had spoken with FC #1's legal guardian and a family member about a visit - If the GHM had approached either of them, it would have been discussed in house and then brought before FC #1's treatment team to discuss if it would be in FC #1's best interest to visit family - It would not have been discussed with FC #1 before anything was finalized - Neither of them would have been in favor of FC #1 visiting family because of some of the family did not have a positive effect on him - They were at a loss as to why the GHM had made the decision regarding FC #1 visiting family without first consulting either of them or the owner of the facility - The QP #1 stated, "We could have put a stop to it." - On 11/18/21, the GHM received a written disciplinary warning due to his failure to inform the facility's clinical team of his plans to have FC #1 visit family on Thanksgiving. Interview on 11/19/21 with QP #1 revealed: - She was always available to staff to talk about anything - If she was not available, the owner of the facility as well as the QP #2 were available to staff, should they have any questions - Staff were always told to ask questions, "I preach to them, I tell them, I demonstrate." - "They (staff) know to ask questions, if they don't understand something." - "Sometimes they think they have power."	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection	V 132		

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V 132	Continued From page 6 G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 7 This Rule is not met as evidenced by: Based upon interview and record review, the facility failed to notify the Department of all allegations against health care personnel and failed to complete an internal investigation. The findings are: Review on 11/29/21 of the North Carolina Incident Response Improvement System (NC IRIS) revealed: - An incident report completed by the Qualified Professional #1 (QP #1) and last submitted to IRIS on 11/19/21 which documented Former Client #1's (FC #1's) "aggressive and destructive" behavior on 11/17/21 - No documentation of an allegation of physical or verbal abuse having been made by FC #1 against the Group Home Manager (GHM) Review on 11/29/21 of FC #1's record revealed: - An admission date of 3/3/21 - Diagnoses: Autism Spectrum Disorder (D/O), Level I (High Functioning Autism); Attention Deficit Hyperactivity D/O, Combined; Oppositional Defiant D/O; Unspecified Depressive D/O; Intellectual Developmental Disability, Mild; Unspecified Trauma and Stress-Related D/O and Conduct D/O - A discharge date of 11/17/21 - FC #1 was 17 years old Interview on 11/29/21 with the Qualified Professionals #1 and #2 (QPs #1 and #2)	V 132		

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V 132	Continued From page 8 revealed: - On 11/17/21, FC #1 became verbally aggressive and physically assaultive towards the GHM and engaged in property destruction at the facility - As a result of FC #1's behavior, involuntary commitment papers were taken out and FC #1 was transported by the police to a hospital for an evaluation on the same date As FC #1 had been discharged from their care on 11/17/21, neither QP (#1 or #2) were aware of FC #1 having made any allegations of verbal or physical abuse against the GHM or that the GHM had provided him with marijuana - A social worker with a Department of Social Services had visited the facility; however, it was to assess whether or not the facility was safe for FC #1 to return to due to the damage, FC #1 had done, including a broken window in his bedroom - Because they were now aware of the allegations, QP #1 reported that she would speak with the GHM - The QP #2 reported she would begin the process of modifying the incident report last submitted to IRIS on 11/19/21 to include FC #1's allegations. Review on 12/3/21 of the IRIS website revealed: - No evidence an updated IRIS report to include the allegations made by FC #1 against the GHM had been submitted as of 12/3/21 Interview on 12/7/21 with the QP #1 revealed: - She had not begun an internal investigation of the allegations made by FC #1 to include meeting with the GHM to discuss the allegations made against him by FC #1 - She had not wished to interfere with the surveyor's ongoing investigation which she knew included interviewing the GHM	V 132		

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V 132	Continued From page 9 - There were no clients currently being served in the facility as the second client in the facility had been discharged the week prior and therefore, the GHM was not working at the present time - Neither she or QP #2 had updated the IRIS report to the Department to include the reporting of FC #1's allegations against the GHM - She would resubmit the incident report to IRIS on 12/7/21 and meet with the GHM as soon as possible.	V 132		

Quality Care III

FACSIMILE TRANSMITTAL

To: Debra Brantan	**Fax #:** 919-715-8078
From: Quality Care III	**Fax #: 336-370-6457**
Pages:	**Date:**
Re: Plan Of Correction (Quality Care III)	

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