Tag 290

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

Qualified Professional will request extra funding to provide extra support in the evenings from 4-7pm or 4-8 pm for the consumer that requires extra attention.

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

Double staffing to prevent any future incidents along with trainings.

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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	MHL041-994	A. BUILDING: _____ B. WING _____	C 01/06/2022

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 A complaint survey was completed on 1/6/22. The complaints were substantiated (intake #s NC00182849 and NC00182886). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients.	V 000		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by	V 290		

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V 290	Continued From page 1 the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide staff-client ratios to enable staff to respond to individualized client needs affecting 3 of 3 clients (#1, #2 and #3). The findings are: Review on 12/20/21 of client #1's record revealed: - An admission date of 4/19/16 - Diagnoses of Autistic Disorder (D/O) and Moderate Intellectual Disability (IDD) - "History and Brief Description" of client #1 which read as follows: "[Client #1] has a history of inappropriate and maladaptive behaviors, such as hitting, biting, kicking, throwing items, self-injury, eloping and pantsing (pulling down pants)	V 290		

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V 290	Continued From page 2 behaviors. [Client #1's] environment should be highly structured with clear expectations. [Client #1] requires constant supervision and redirecting (without using 'no'). His short attention span requires support ..." - " ...[Client #1] requires full assistance with protecting himself from exploration because he is a vulnerable induvial. He requires support with being understood and understanding others. Safety is an issue due to him wandering, staff should continue monitoring and redirection to stay close. [Client #1] requires support when it comes to prevention of self-injurious behaviors such as biting himself and putting items in his ears. He requires support with the inappropriate sexual behavior such as grabbing woman, inappropriate touching/gestures, exhibitionism and exposing self in public ..." - Client #1's triggers included "disrespectful/inconsistent staff, hunger, getting frustrated, wanting more food, red 40 (dye found in red sauces), a lot of preservatives (found in food), aggressiveness, rushing (with getting up in the middle of the night), being told no, transitioning, becoming bored and constipation ..." Review on 1/6/22 of client #2's record revealed: - An admission date of 5/15/18 - Diagnoses of Autistic D/O with Accompanying Intellectual Impairment; Moderate IDD and Schizophrenia, Unspecified - Client #2 required one-on-one staff to attend activities at the YMCA, 24-hour supervision and should never be left alone Review on 1/6/22 of client #3's record revealed: - An admission date of 2/17/17 - A diagnosis of a Traumatic Brain Injury - Client #3 required 24-hour supervision and a	V 290		

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V 290	Continued From page 3 highly structured environment - Client #3 was a registered sex offender Review on 12/17/21 of the North Carolina Incident Response Improvement System (NC IRIS) website revealed: - An incident report completed by the Qualified Professional (QP) and last submitted on 10/29/21 which reflected that on 10/27/21 at 6:00 pm "[Client #1] was outside playing in the yard, while staff (staff #1) was monitoring [client #1] ran across and went to the home on the right [client #1] jumped on a 90 year old laday and was put in a therapeutic hold by staff and then [client #1] was returned home." Review on 12/20/21 of a "behavior log" revealed: - On 10/27/21, staff #1 documented "[Client #1] ran off on staff (#1) into the neighbor's yard. He made contact with a lady and fell on the ground. The police was called out behind this matter. This happened around 5:30 pm. After all of this he calmed down, ate dinner and went to bed." Interview on 12/17/21 with the family member of the neighbor involved in the incident on 10/27/21 revealed: - She learned about the events of 10/27/21 from the gentleman who mowed her family member's yard - She did not report what date she learned about the incident - The gentleman reported to her that on 10/27/21, he observed client #1 "running up on" her family member and he began to "grab the family member's arm" and pull on her shirt - Her family member began "screaming" as client #1 began "grabbing at her breasts." - He did not inform her client #1 pulled the family member's pants down	V 290		

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V 290	Continued From page 4 - As a result of the incident, the Sheriff's Department was called to investigate the matter on the same date - Although her family member was not injured, she was frightened by client #1's actions and it had concerned others in the neighborhood - Other neighbors who learned of the incident were upset as several of the individuals in the neighborhood were older and liked to spend time outside in their yards - Since the incident on 10/27/21, the owner of the facility had met with her family member to apologize and give them flowers - While she appreciated this gesture, she believed more had to be done to ensure the safety of those in the neighborhood as well as the clients who resided at the facility. No attempt was made to interview the person client #1 confronted on 10/27/21, because her family member did not want her to be upset by having to discuss the events of that day. The family member also reported her relative had issues with memory loss and might not be able to recall what happened that day. Interview on 12/17/21 with the person who observed the events of 10/27/21 revealed: - He provided lawncare services for several "older persons" who resided in the neighborhood - On 10/27/21, he was at the home of one of his customers, an elderly female, sitting on his lawnmower, preparing to cut her lawn - He stated, "I saw a young boy (client #1) come out of the house (the facility) and saw him walking down the street by himself." - He didn't see anyone else with client #1 - Client #1 "veered across the street towards them and went straight towards [the female.]" - "Suddenly he went to her and pulled her	V 290		

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V 290	Continued From page 11 client #1 to include increased staffing. Review on 1/6/22 of a Plan of Protection completed by the QP #1 on 1/6/22 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure the safety of the consumer and others, we will put a staff in place from 4 pm until 7 pm immediately to cover the peak hours, until we can get additional funding for staffing. During this time, there will be two staff to accompany all consumers during outside and community activities." - "Describe your plans to make sure the above happens: Effective 1/7/22 a staff will be placed in the home from 4 pm until 7 pm." The facility served three adult clients whose diagnoses include Autistic Disorder, Moderate Intellectual Disability, Schizophrenia and Traumatic Brain Injury. Client #1 had a history of behaviors, which included grabbing women, inappropriate touching/gestures and pulling down the pants of others. He was not allowed any unsupervised time in the home or the community and was assigned a one-on-one staff Monday through Friday from 8 am until 3 pm only. Clients (#2 and #3) required 24-hour supervision and had no unsupervised time in the home or the community. Client #3 also required a highly structured environment and was a registered sex offender. On 10/27/21, while outside with one staff present, client #1 ran to a neighbor's home and pulled down the pants of an elderly woman standing in her yard. A male standing outside with the woman intervened and pulled client #1 away from her and per his report, held him until staff arrived approximately ten to fifteen minutes later. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and	V 290		

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V 290	Continued From page 5 pants down to her underwear." - He immediately got off his lawnmower and was able to "pull" client #1 away from the female - "I didn't hurt him or anything ...I didn't assault him." - He knew "something was wrong with him" because he had heard him yelling in the backyard at the facility before - Client #1 attempted to move back towards the female but he was able to keep him from moving towards her - He directed the woman to go inside the home and call police - As he was standing with client #1, "the group home guy" ran across the street and took client #1 by the arm and walked him back to the facility - It was between ten and fifteen minutes before staff came to retrieve client #1 - He was concerned about the safety of the people who lived in the neighborhood - "Sometimes they are out in the yard." - "If they want them (facilities/clients) in this area, supervision needs to be a plus." Interview on 12/20/21 with staff #1 revealed: - He had worked at the facility for "no more than two to three months" and worked on an as needed basis - He worked with all the clients; however, client #1 "requires the most attention." - The incident happened around 4:45 pm on 10/27/21 and he was the only staff present in the facility at the time - He and client #1 were outside in the yard (jumping on the trampoline and running laps around the facility) when client #1 "dashed off running." - Client #1 "tried to get to the woman (neighbor across the street) but fell." - He could see client #1 as he was running	V 290		

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V 290	Continued From page 6 towards the neighbor's home He was "right there" with client #1 and yelled at client #1 to stop, however, there was a man in the woman's yard who was mowing the lawn and client #1 could not hear him over the sound of the lawnmower - Client #1 would listen, "If you use a heavy voice;" however, client #1 couldn't hear him that day - He never saw the woman's pants fall because she fell to the porch and he was able to "grab" client #1 and walk him back to the facility - The woman at the home was yelling and screaming, "Y 'all need to do something with him" and reported she was going to call police - Neither client #1 nor the neighbor had sustained any injuries - He telephoned the agency's office and spoke to the QP #2 to tell her what happened - Police officers arrived at the facility the evening of 10/27/21 - Staff #1 explained to the officers that client #1 had limited communication skills and would not be able to explain what had happened - He told the officers that it was his fault client #1 went to the neighbor's home as he should have kept client #1 within arm's length while they were outside - "Most issues are with him wanting to have ice cream ...on this particular day, he was amped up." - "He's (client #1) a good fellow, he does listen, but you have to be firm with him." No attempt was made to interview client #1 due to his limited communication and cognitive skills. Observation on 12/17/21 at approximately 2 pm revealed: - Staff #2 present in the facility with clients (#2	V 290		

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V 290	Continued From page 7 and #3) also present in the home - No other staff were present in the home Interview on 12/17/21 with staff #2 revealed: - He worked at the facility Monday through Friday from 8 am until 4 pm - Client #1 required constant supervision and had no unsupervised time in the home or in the community - Staff #3 worked with client #1 as his "one-on-one" staff from 8 am until 3 pm Monday through Friday - He worked with client #1 from 3 pm until 4 pm each day he worked with no other staff present until 4 pm - He was not on shift on 10/27/21 and had no firsthand information regarding what happened between client #1 and a female neighbor - Client #1 was "fascinated by women ...however, he would never intentionally cause anyone any harm." - He had never observed client #1 be aggressive towards a female - Since the events of 10/27/21, staff had met with the agency's QP's (#1 and #2) during the same week of the incident the QP's (#1 and #2) reiterated to staff that client #1 must be supervised at all times and watched even more closely than ever. Observation on 12/17/21 at 3 pm revealed: - Staff #3 arrived at the facility with client #1. Interview on 12/20/21 with staff #3 revealed: - She worked at the facility Monday through Friday from 8 am until 3 pm - She worked specifically with client #1 during her shift and was client #1's "one-on-one" staff - Client #1 did not have any unsupervised time in the home or in the community	V 290		

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V 290	Continued From page 8 - She worked with client #1 on his goals as well as "I keep him busy, take him to do things he likes ..." - When working with client #1, he required constant supervision and she always had him in her sight - Staff must be firm with client #1. "If he feels like he can get over on you, he will." - She didn't want him to feel as if she were "constantly on his back, but I am." - Client #1 can he "hardheaded and stubborn ...you have to use your big boy voice." - She had no firsthand knowledge of the events of 10/27/21; however, she had participated in a Zoom meeting, where the facility's clinical staff reiterated the importance of monitoring client #1 closely - She could not recall the date of the Zoom meeting. Observation on 12/17/21 from approximately 3:15 pm until 4 pm revealed: - Staff #2 as the only staff present in the facility with clients (#1, #2 and #3) Observation on 12/17/21 from approximately 4 pm until 4:15 pm revealed: - Staff #4 as the only staff present in the facility with clients (#1, #2 and #3) in the home Interview on 12/20/21 with QP #1 revealed: - Staff #1 reported to her that he and client #1 were outside when client #1 observed a neighbor come outside to pay the gentleman who was mowing her lawn - It was at this time, client #1 ran across the street and approached the neighbor and pulled her pants down - She and the QP #2 visited the neighbor on 10/28/21 to apologize to her for client #1's	V 290		

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V 290	Continued From page 9 behavior - The neighbor reported that as she stepped outside, client #1 "was there but that man got him off her." - The neighbor did not indicate who the "man" was that intervened to help her - QP #1 stated the neighbor appeared to be in her "80's or 90's" (age) - She and the QP #2 had spoken with all staff and specifically with staff #1 about the events of 10/27/21 - Staff #1 reported to her that he and client #1 were outside when client #1 ran across the street - She reviewed client #1's record with staff #1 for a second time and discussed client #1's triggers and how not to become complacent when working with client #1 - She reiterated to staff #1 the importance of keeping client #1 within arm's length at all times - She reported that when she has worked with client #1, she would hold his hand when she did not feel comfortable with his willingness to remain close to her - She recognized she would not be able to catch client #1, if he began to run from her - She was in the process of developing a training for all staff to ensure staff were mindful of each of the clients' specific needs and the degree of supervision they required. Interview on 12/20/21 with QP #2 revealed: - She was aware of the events of 10/27/21 - She had worked for client #1 for years and he had "come a long way" - When working with client #1, it was important to be vigilant and monitor for any changes in his behavior - Since the events of 10/27/21, client #1 had been seen by his physician on 12/17/21 and had been referred to a neuropsychiatrist for further	V 290		

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V 290	Continued From page 10 evaluation - His physician was also considering increasing his dose of Prozac to see if this would influence his behavior - She and the QP #1 had been talking with staff about the seriousness of monitoring client #1 when he was outside the facility or in the community. Interview on 1/6/22 with QP #1 revealed: - Client #1 remained in the facility and there had been no other incidents - Staff #3 continued to work with him during the day as his one-on-one staff; however, client #1 was not assigned a one-on-one staff after 3 pm or on the weekends - Client #1 did not have any behaviors after bedtime, other than to get up to go to the bathroom - There had been no incidents involving inappropriate behaviors by clients (#2 and #3) - She understood the need to keep the clients safe and to have adequate staffing to meet client needs. Interview on 1/6/22 with QP #2 revealed: - Confirmation of what the QP #1 had shared regarding client #1's one-on-one staffing from 8 am until 3 pm - There had been no other incidents involving client #1 and others in the neighborhood - Client #1's dose of Prozac had been increased from 20 mg to 30 mg per day - She was still awaiting an appointment for client #1 to meet with the neuropsychiatrist - She understood the need to keep the clients safe and to have adequate staffing to meet client needs - She would begin the process of trying to get additional funding for "enhanced" services for	V 290		

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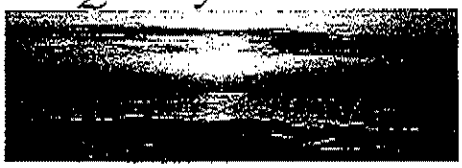
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE III, LLC/HICKORY TREE HOME	4010 HICKORY TREE LANE GREENSBORO, NC 27406

(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 290	Continued From page 12 welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 290		

Quality Care III



FACSIMILE TRANSMITTAL

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