

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>INITIAL COMMENTS</p> <p>A follow up survey was completed on 4/14/22. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>The facility is licensed for a census of 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p>	{V 000}		
{V 290}	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(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.</p> <p>(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.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(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 the governing body; or</p>	{V 290}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 1</p> <p>(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.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(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</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record review, interview and observation, 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:</p> <p>Review on 4/13/22 of client #1's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 4/19/16 - Diagnoses of Autistic Disorder (D/O) and Moderate Intellectual Disability (IDD) - An admission assessment (no date listed and no signature to indicate who completed the assessment) which revealed client #1 "...requires 24-hour supervision and highly structured environment..." - A treatment plan dated 4/1/22 that reflected client #1 needed staff support to prevent 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 2</p> <p>emotional outbursts. "...Staff to anticipate and monitor for escalating behaviors..."</p> <ul style="list-style-type: none"> - "...[Client #1's] behavior can escalate to property destruction, physically assaulting or injuring others..." - Client #1 also engaged in "tantrum behavior defined as one or more of the following screaming, biting arm, knocking over furniture, physical aggression. Pantsing: defined as pulling or attempting to pull down the pants of others, particularly females..." - "Prevention of nonaggressive but inappropriate sexual behavior (e.g., exposes self in public, exhibitionism, inappropriate touching or gesturing)..." His behaviors also included "approaching aggressively women, may try to grab women. Specifically, with women at the swimming pool and with women in bathing suits. Monitor tablet and block pornography. On 6/1/21 [client #1] was redirected to go outside when he was having a behavior, however once outside [client #1] pulled his pants down and was sexually touching himself..." - "Prevention of wandering - [client #1] will get upset at the group home and run out of the door and running away. [Client #1] has run to a neighbor's house..." - Client #1 needed "full physical assistance hourly because of how vulnerable [client #1] is to exploitation..." - A section of the treatment plan which documented "What is NOT Working?" revealed: Client #1 did not have a "structured schedule," he was "putting stuff in his ears" and he had jumped out of his bedroom window and left the facility - Client #1 also had behaviors which included "biting himself, being aggressive, throwing items and sexually pleasuring himself outside." - As a result of these behaviors, the facility had sought the services of an individual to complete a 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 3</p> <p>Behavior Support Plan (BSP) on behalf of client #1 to assist staff in better understanding and working with him; however, it had not been completed yet</p> <ul style="list-style-type: none"> - Information for a BSP completed on 3/31/17 on behalf of client #1 revealed: "...Proactive Strategies" that included "...staff will provide visual supervision to [client #1] within arm's reach in all environments. Staff will increase monitoring and increase their level of supervision in crowded environments, such as the YMCA (Young Men's Christian Association), swimming pools, etc. Staff will place themselves in between [client #1] and others in all environments at all times in an effort to block his access to other people..." <p>Review on 4/11/22 of client #1's "client specific" information form (no date listed as to when it was completed) revealed:</p> <ul style="list-style-type: none"> - "...[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..." <p>Observation on 4/11/22 at 2:30 pm revealed:</p> <ul style="list-style-type: none"> - Clients (#1 and #2) in the facility with only one staff (#1) present <p>Observation on 4/11/22 from 2:30 pm until 3:30 pm revealed:</p> <ul style="list-style-type: none"> - Client #1 constantly walked around the facility office - He went to and from the office to his bedroom and/or bathroom located just outside of the office and then would return to the office - He continually repeated the words, "candy, ice cream, outside" to staff #1 - Staff #1 followed client #1 whenever he left the room or called out to him to return to the 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 4</p> <p>office</p> <ul style="list-style-type: none"> - When client #1 returned to the office, he continued to move throughout the office and would only sit briefly before getting back up - Client #1 opened the drawers on the desk used by staff and appeared to look for something - Staff #1 told client #1 there was no candy in the desk, if that's what he was looking for - Client #1 went downstairs and staff #1 followed behind him - Staff #1 could be overheard directing client #1 to close the freezer door of the refrigerator and tell he he could not give him whatever client #1 had found in the freezer as it belonged to someone else - Staff #1 provided directives to client #1 in a firm tone and client #1 appeared to understand and followed the directives; however, client #1 repeated the same behaviors - While staff #1 and client #1 interacted with each other, client #2 was observed to be in his bedroom located near the staff office <p>Review on 4/13/22 of client #2's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 5/15/18 - Diagnoses of Autistic D/O with Accompanying Intellectual Impairment; Moderate IDD and Schizophrenia, Unspecified <p>Interview on 4/11/22 with client #2 revealed:</p> <ul style="list-style-type: none"> - Client #1 had recently left the facility without staff permission - Client #2 reported client #1 had only left the facility once but could not provide any additional information - Client #2 would not answer any additional questions about himself or clients (#1 and #3) <p>Review on 4/13/22 of client #3's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 2/17/17 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 5</p> <ul style="list-style-type: none"> - A diagnosis of a Traumatic Brain Injury - He was a registered sex offender <p>Interview on 4/12/22 with client #3 revealed:</p> <ul style="list-style-type: none"> - One evening, (he could not recall the date), he saw a window screen hit the ground outside his bedroom window located on the first floor of the facility - He informed the staff who was on duty what he had seen - He could not remember who was working that evening; however, he did remember it was a female and she was the only staff present in the facility with him and clients (#1 and #2) - He went outside and told whoever might have been outside, to get away from the facility; although he had "only seen a shadow." - When he informed staff what he had seen, he had observed her upstairs in front of client #1's bedroom door - Staff checked on clients (#1 and #2) and realized client #1 had jumped out of his bedroom window - It had been no more than an hour, from the time he observed the window screen hit the ground until client #1 was returned to the facility by law enforcement - He was thankful client #1 did not hurt himself or anyone else while he was away from the facility - This was the only time he was aware of client #1 having left the facility through his window or having left the facility without staff permission - He and client #2 had not left the facility without the staff's permission - He believed the best way to work with client #1 was for client #1 to have "one on one staff, twenty-four, seven." - Client #1 was a lot smarter than he appeared and "is constantly playing games." - "He knows what he is doing." 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 6</p> <ul style="list-style-type: none"> - Staff "have their hands full with [client #1]." <p>Review on 4/11/22 of "communication and behavior logs" from 2/23/22-4/10/22 revealed:</p> <ul style="list-style-type: none"> - On 2/26/22, client #1 was at the hospital with the Qualified Professional #1 (QP #1) - There was no other documentation to indicate why client #1 was at the hospital - On 3/6/22, client #1 went into a neighbor's yard and sat down for "five minutes." Client #1 was retrieved by staff and returned to the facility without incident - On 3/11/22, client #1 attempted to run away from staff while walking outside (no additional details noted) - On 4/4/22, client #1 broke a dish and on 4/8/22, client #1 broke a television remote - Client #1's other behaviors during this time frame included his yelling and screaming, becoming agitated when impatient and then biting himself - Client #1 required constant redirection and prompting to address these behaviors <p>Interview on 4/11/22 with staff #1 revealed:</p> <ul style="list-style-type: none"> - He worked Monday through Friday from 8 am until 4 pm - He primarily worked with client #2; however, the staff who worked primarily with client #1 was on vacation and he had been responsible for working with both clients (#1 and #2) on 4/11/22 - He was familiar with client #1's behaviors, treatment goals and need to be constantly monitored - Earlier in the day, he and clients (#1 and #2) had been at the park and while he interacted with and monitored client #1, client #2 played basketball with friends - He reported he was able to interact with and monitor client #1 as well as monitor client #2 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 7</p> <ul style="list-style-type: none"> - He was not aware of client #1 having gone AWOL recently or having engaged in any inappropriate behaviors while in the community <p>Interview on 4/11/22 with staff #2 revealed:</p> <ul style="list-style-type: none"> - Until recently, she had been assigned to work as client #1's one-on-one staff from 4 pm until 9 pm while a second staff remained in the facility with clients (#2 and #3) - Her hours had recently changed due to the termination of a second shift staff - When she had worked with client #1, she kept him in the community and engaged in activities he enjoyed - She fully understood the need to keep client #1 under close supervision as he could be "tempted to run off;" however, he had not gone AWOL while out in the community with her - On 2/26/22, she was in the office preparing to administer clients' (#2 and #3) their medications - She had already administered medication to client #1 and assisted him in getting ready for bed - At approximately 8:25 pm, client #3 informed her he had seen a window screen drop outside in front of his bedroom window located on the first floor of the facility - She went into client #1's bedroom and observed the window up, the screen was missing from the window and client #1 was not in his room - She went downstairs and checked the front and backyard of the facility to see if she could locate client #1 - As she could not leave clients (#2 and #3) alone in the facility to go look for client #1, she called the QP #1 to report what had happened and then called 911 to report client #1 missing - "Within five minutes," she received a telephone call from a law enforcement officer who reported client #1 had been located and would 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 8</p> <p>be returned to the facility</p> <ul style="list-style-type: none"> - Client #1 returned to the facility in handcuffs and dressed in only his underwear and slippers - She did not know where he had been located; however, someone had called to report client #1 in their yard - The QP #1 transported client #1 to the hospital for evaluation as he may have been injured when he jumped out of his window - Client #1 was away from the facility for no more than 45 minutes; however, she had been worried that while client #1 was in the community unsupervised, he could have been hit by a car or harmed by someone - Client #1 remained at the hospital overnight and returned to the facility on 2/27/22 <p>Interview on 4/12/22 with the QP #1 revealed:</p> <ul style="list-style-type: none"> - After the facility had been cited for failure to meet the supervision needs of the clients (#1, #2 and #3) (in January 2022); based in part on client #1 having pulled down the pants of an elderly neighbor (in October 2021), she contacted client #1's care coordinator with his managed care organization to request assistance in getting additional funding to provide a one-on-one staff for client #1 during the evenings - Although client #1's care coordinator informed her client #1 would need a behavior support plan before he would be eligible for a one-on-one staff, the facility hired staff #2 to work specifically with client #1 from 4 pm until between 8 pm and 9 pm - She and other staff had also assisted in providing additional staffing on behalf of client #1 until additional funding was secured - On 2/26/22, she received a telephone call (between 8 and 8:30 pm) from staff #2 who reported client #1 had jumped out of his bedroom window and left the facility without staff 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 9</p> <p>supervision</p> <ul style="list-style-type: none"> - Staff #2 was the only staff present at the time client #1 left the facility - She arrived at the facility 8:45 pm and within minutes of her arrival at the facility, client #1 was returned to the facility by law enforcement officers - She observed client #1 to be clad in only his underwear and could not recall if he had on any shoes - She was informed by the officers that client #1 had been located while walking in the neighborhood - She transported client #1 to a local hospital to determine if he had been injured after he jumped out of his window or while he was away from the facility - Client #1 was kept overnight for observation and to be assessed for admission to the hospital's behavioral health unit - Although client #1 liked standing in his window and looking out, he had never attempted to jump out of a window prior to 2/26/22 - While at the hospital, client #1 appeared to be "like a zombie" and "delusional." - She spoke with a physician at the hospital about client #1's behavior and reported the medications he was taking, including Zolpidem Tartrate (Ambien) - She believed because client #1 had been administered Ambien prior to his going to bed, this could have contributed to his jumping out of his window - Client #1 was released from the hospital on 2/27/22 with having sustained no injuries or need to be admitted to the hospital's behavioral health unit - "It was like nothing happened." - She believed client #1's fall may have been cushioned by the bushes in front of his window - While she had worked with client #1 for years 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 10</p> <p>and felt comfortable in managing his behaviors, she acknowledged that "sometimes his behaviors come from nowhere."</p> <ul style="list-style-type: none"> - "His behavior can be startling." - The facility was in the process of having a BSP developed on behalf of client #1; however, the behavior support specialist had not met with client #1 yet but was in the process of reviewing his treatment plan and behavior logs <p>Observation on 4/11/22 at 3 pm of client #1's bedroom revealed:</p> <ul style="list-style-type: none"> - It was located on the second floor of the facility with windows facing towards the street <p>Observation and measurement of the distance of client #1's bedroom window to the ground beneath his window on 4/14/22 at 1:55 pm revealed:</p> <ul style="list-style-type: none"> - It was ten feet from client #1's bedroom window to the ground below his window - A small tree and azalea bushes were planted directly beneath client #1's window and along the front of the facility - A row of red bricks provided a border along the ground in front of the small tree and the bushes <p>Review on 4/13/22 of the 911 "Dispatch History" from 2/20/22-4/13/22 for the address listed for the facility revealed:</p> <ul style="list-style-type: none"> - On 2/26/22, a female called 911 at 8:36 pm to report a "naked man" was ringing her doorbell - She reported that she was afraid he was trying to break into her home and that he had a gun - The female provided a description to 911 that the individual was an African- American male between 30 and 40 years of age - Staff #2 called 911 at 8:38 pm to report client 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 11</p> <p>#1 had "jumped out 2nd floor window and ran away."</p> <ul style="list-style-type: none"> - She reported client #1 was described as an African American male, 25 years of age and dressed in a gray t-shirt and gray shorts - Staff #2 also advised 911 dispatch that client "may be combative and may be injured from jumping out of 2nd floor window..." - 911 notes (9:07 pm) reflect client #1 was found and returned to the facility. Client #1's name was listed and that he was non-verbal and autistic <p>Observation on 4/14/22 of the distance between client #1's home and the home where on 2/26/22 the caller to 911 reported a "naked man" on her porch revealed:</p> <ul style="list-style-type: none"> - It was three tenths of a mile from the facility to this home - Client #1 had to cross a two-lane road to get to the home <p>Review on 4/14/22 of the weather conditions via the website: www.weather.gov revealed:</p> <ul style="list-style-type: none"> - The temperature on 2/26/22 ranged between a high of 47 degrees Fahrenheit (F) and a low of 38 degrees (F) with an average temperature of 42.5 degrees (F) <p>Review on 4/14/22 of a Plan of Protection completed by the QP #1 on 4/14/22 revealed:</p> <ul style="list-style-type: none"> - "What immediate action will the facility take to ensure the safety of the consumers in your care? Clinical staff will work immediately to host an extensive training for all staff. Clinical staff will work with the consumer when additional staffing is not found for not only Week days, but weekends to ensure that the staff requirement is met 7 days a week." - "Describe your plans to make sure the above 	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 12</p> <p>happens: Director will monitor to ensure no future situation errors take place."</p> <p>The facility served three adult clients whose diagnoses include Autistic Disorder, Moderate Intellectual Disability, Schizophrenia and Traumatic Brain Injury. None of the clients had unsupervised time in the home or the community. Client #1 had a history of having emotional outbursts which could escalate to property destruction, physically assaulting or injuring others as well as engaging in exhibitionism, the inappropriate touching of others, (especially women) and pulling down the pants of others. Based on these behaviors, client #1 was assigned a one-on-one staff from 8 am until 3 pm each day and during the evenings from 4 pm until between the hours of 8 pm and 9 pm per staff report. On 2/26/22, with only one staff (#2) present in the facility, client #1 jumped out of his bedroom window on the second floor of the facility and ran away. Client #1 went to a home in another neighborhood and began ringing the doorbell. The person in the home called 911 and reported they were afraid client #1 had a gun and was attempting to break into her home. Because clients (#2 and #3) could not be left alone in the home or the community based on their histories, including client #3 being a registered sexual offender, staff #2 could not leave the home in an attempt to locate client #1, so law enforcement was called. Law enforcement officers located client #1 and returned him to the facility without incident; however, client #1 was hospitalized overnight for assessment of any injuries and to evaluate his mental status given that he had jumped out of a second-floor window. This deficiency constitutes an Imposed Type B rule violation which is detrimental to the health, safety and welfare of the clients. An administrative</p>	{V 290}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 13 penalty of \$200.00 per day is imposed for failure to correct within 45 days	{V 290}		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	<p>Continued From page 14</p> <p>erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	<p>Continued From page 15</p> <p>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all level II incidents were reported within 72 hours of the incident to the Local Management Entity (LME) responsible for the catchment area where services were provided. The findings are:</p> <p>Review on 4/13/22 of client #1's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 4/19/16 - Diagnoses of Autistic Disorder (D/O) and Moderate Intellectual Disability (IDD) <p>Review on 4/11/22 of "communication and behavior logs" from 2/23/22-4/10/22 revealed:</p> <ul style="list-style-type: none"> - On 2/26/22, client #1 was at the hospital with the Qualified Professional #1 (QP #1) - There was no other documentation to indicate why client #1 was at the hospital <p>Interview on 4/11/22 with staff #2 revealed:</p> <ul style="list-style-type: none"> - While working at the facility on 2/26/22, client #1 jumped from his second-floor bedroom window and left the facility without staff supervision - As she could not leave clients (#2 and #3) 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	<p>Continued From page 16</p> <p>alone in the facility to go look for client #1, she called the QP #1 to report what had happened and then called 911 to report client #1 missing</p> <ul style="list-style-type: none"> - "Within five minutes," she received a telephone call from a law enforcement officer who reported client #1 had been located and would be returned to the facility - Client #1 was returned to the facility and then the QP #1 transported client #1 to the hospital for evaluation as he may have been injured when he jumped out of his window - Client #1 remained at the hospital overnight and returned to the facility on 2/27/22 <p>Review on 4/11/22-4/13/22 of the North Carolina Department of Health and Human Services Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - No evidence of an incident report regarding client #1 jumping out of his bedroom window and leaving the supervision of staff #2 on 2/26/22 which resulted in law enforcement being called <p>Interview on 4/14/22 with Qualified Professional #1 (QP #1) revealed:</p> <ul style="list-style-type: none"> - She felt certain the QP #2 (who was currently out sick) had completed an incident report; however, based on her review of what the QP #2 had printed after she completed the report, the QP #2 had failed to submit it properly, so it registered in the system - She would ensure the incident report was submitted to IRIS immediately 	V 367		