STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-885	A. BUILDING: _____ B. WING _____	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARDEN HOME	3104 DARDEN ROAD GREENSBORO, NC 27407

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V 000	INITIAL COMMENTS A complaint survey was completed on September 6, 2022. The complaint (Intake #NC00192374) was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection 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	V 132		

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V 132	Continued From page 1 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Department (HCPR) was notified of allegations against facility staff, provide evidence that the allegation was investigated, and report the finding of the investigation to the Department within five working days of making the initial report affecting 1 of 3 clients (client #1). The findings are: Review on 9/2/22 of client #1's record revealed: -An admission date of 1/1/09 -Diagnoses of Schizoaffective Disorder, Depressive Type, Obsessive Compulsive Disorder, Mild Mental Retardation, History of Hypertension, Constipation and Other Psychosocial and Environmental Problems	V 132		

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V 132	Continued From page 2 Review on 9/1/22 of the facility's Incident Report revealed: -An incident on 8/10/22 where client #1 eloped from the facility -Mentioned in the incident report was an allegation of client #1 reporting a staff hit him with a broom -No internal investigation was conducted to investigate this allegation -No documentation the HCPR was notified of the allegation Review on 9/1/22 of the North Carolina Incident Response Improvement System (IRIS) revealed: -"The provider determined that staff failed to comply with policy and procedures to ensure client safety. The provider responded by updating staff alert systems, currently in talks with the home's landlord to implement an outdoor camera system to assist with monitoring the home perimeter. Staff has been in-serviced regarding bed checks, room checks, and shift change responsibility. Both staff members were placed on a 30-day evaluation and written disciplinary action. The provider continues to provide additional staff supervision to assist staff with identifying times when extra support is necessary and appropriate based on client specifics and to ensure staff complies with all agency policies and procedures. The provider will contact DSS (Department of Social Services) to receive the report completed. Contact to be made 8/18/22. [A local hospital's staff] did make the provider aware of [client #1] communicating that '[a name] hit him with a broom' when [a local hospital's staff] informed [client #1] he would be discharged. The provider has no staff member named [a name], and the closest person to the name communicated by [a local hospital] that works in the home is [a name]. This staff member only	V 132		

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V 132	Continued From page 3 works weekends and was not present at the time of the event. DSS did follow up, but the provider received no paperwork regarding the event. The provider contacted DSS to receive the report completed. The provider made contact on 8/18/22, and a message was left. The provider will make the information available once the report is completed. The provider has resubmitted the hospital discharge paperwork under the attached documents section in IRIS." Interview on 9/1/22 with client #1 revealed: -Client #1 spoke in a very soft voice -Stated he wanted to live by himself -Staff treated him fine. "They are funny. There is a blue car in the driveway." -"I was in the living room and the cable box was next to the wall. The satellite was outside. I pay $69. I have a new partner for me. She's a nurse. Back in the window of my bedroom. Alarm. I pulled it off. I got out of my bed and met a guy with a silver car. He kicked me. His name was (spelled out) DAEEDUI JUI." -Denied any staff harming him, hitting him or the other clients -Stated the broom was at the driveway Interview on 9/1/22 with the RD revealed: -Client #1's windows had alarms on the outside now -The facility also erected a motion sensor outside client #1's window -Staff #1 and staff #2 were written up and retrained on bed checks, room checks, alarm checks and staff shift change -The main focus of the facility on the day client #1 eloped from the facility was to locate him. -A storm came through and knocked the cable out -Client #1 got upset and was redirected to watch	V 132		

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V 132	Continued From page 4 Roku (streaming alternative to watching television) instead -Roku did not have the same channels as client #1 was used to watching -Client #1 eventually calmed down and went to bed. -Staff #1 left the facility "as he is only there during peak hours (4pm to 9pm)" -Staff #2 came in from 4pm to 12am -Staff #3 came in at 11:30pm -Staff #2 and staff #3 failed to conduct bed checks as required -"The bed checks are to be done every 15 minutes and recorded every 30 minutes. They failed to do this." Interview on 9/1/22 with the QP revealed: -Had completed the facility's incident report -Had not conducted an internal investigation in written form -Did not submit a 72-hour report to the HCPR -Would immediately conduct the internal investigation into client #1's allegation of being hit with a broom by staff -Would immediately notify the HCPR of client #1's allegation of being hit with a broom by a staff	V 132		
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	V 367		

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V 367	Continued From page 5	V 367		

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 erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(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

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V 367	Continued From page 6 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). (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: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 367		

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facility failed to report all level III incidents to the LME/MCO (Local Management Entity/Managed Care Organization) within 72 hours of learning of the incident. The findings are:

Review on 9/2/22 of client #1's record revealed:
-An admission date of 1/1/09
-Diagnoses of Schizoaffective Disorder, Depressive Type, Obsessive Compulsive Disorder, Mild Mental Retardation, History of Hypertension, Constipation and Other Psychosocial and Environmental Problems

Review on 9/1/22 of the facility's Incident Reports revealed:
-An incident on 8/10/22 where client #1 eloped from the facility
-Mentioned in the incident report was an allegation of client #1 reporting a staff hit him with a broom

Further review on 9/1/22 of the facility's level III incident report revealed:
-"AbleCare Corporation (ABC) did an internal investigation regarding the events that occurred on 8/10/22. ABC determined that on 8/9/22, [client #1] became upset when [staff #1] and [staff #2] discovered that the [cable company]'s app lost service due to outages caused by the storm. [Staff #1] and [staff #2] began processing with the client to inform him of the outage and that facility staff could do nothing until the cable company addressed the outage. [Client #1] struggled to process the events and escalated the behavior incident by throwing his notebook into the TV. Facility staff responded to the event with continuing processing and a basic explanation of the event. The staff were able to get [client #1] to calm down by offering other alternatives to ensure his entertainment needs were met. [Staff

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V 367	Continued From page 8 #2] exited the home after things had calmed down, and [client #1] appeared to have calmed down and had a more positive outlook. As the night progressed, [staff #1] assisted [client #1] with the bathroom routine and preparation for sleep. [Staff #1] asserts to completing a bed check at 10:00 pm, and all consumers were accounted for and sleeping in their rooms. According to [staff #1], he proceeded to complete nightly shift duties that complied with maintaining a safe, clean area for the consumer. [Staff #3] arrived at the home at 11:05 pm and obtained the shift from [staff #1]. At the point of turnover, [staff #1] communicated to [staff #3] from [staff #1] that the consumers were all asleep. [Staff #3] asserts to completing other nighttime duties, excluding making rounds to ensure overall safety and well-being. The next morning, 8/10/22, Staff discovered that [client #1] had exited the home and maneuvered past the current alert system. [Staff #3] immediately contacted [the Residential Director (RD)] at 7:02 am and informed him that [client #1] had eloped from the program. [The RD] instructed [staff #3] to contact 911 for assistance from [the local police department] at 7:08 am. ABC's primary point of contact with the local police department was [responding officer's name]. [The RD] arrived at the home shortly after to communicate with the police officer regarding the consumer's historical tendencies and favorite places of visit in similar historical episodes. ABC collaborated with the police officer to ensure that they had pertinent information such as [client #1]'s date of birth, social security number, a photograph of the client and current medication chart. [The RD] requested a check of the hospital and hospital system be completed. [The police department] communicated that it had completed a system check, and the results were negative. [The police department] then put a drone in the	V 367		

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V 367	Continued From page 9	V 367		

air to identify any leads that would allow officers to locate [client #1]. This action also resulted in no results. [The Qualified Professional (QP)] was informed at 7:06 am, arrived at the area around 9:45 am, and assisted in locating [client #1]. After an hour of looking with no success, [the QP] contacted [the Care Coordinator] to inform her of current events. [The QP] then contacted [a local hospital] at 12:15 pm and requested information about individuals that checked in under the [client #1's name] to no avail. [The QP] requested additional information of any unknown or unnamed individuals that may have checked into the facility to no avail. [The QP] then contacted [a second hospital] at 12:20 pm and sought out information to no avail. The ABC administration staff continued all research efforts around the area, followed by an in-person visit at 1:00 pm to [a local hospital] by ABC's [Clinical Director (CD)]. [The CD] requested similar information that [the QP] requested earlier in the day to no avail. At 2:34 pm, [the QP] and [the RD] contacted the non-emergency number to check the status of the search. [The local police department] contacted [the QP] at 2:36 pm, informing him of no changes. They reported that an active silver alert was activated but lacked a known outfit and direction of travel. [The QP] and [the RD] continued the investigation and were able to confirm [client #1]'s last known outfit. Aware of an outfit worn the previous day and checking his room, we determined his last known outfit to be a turquoise shirt, khaki shorts, and black and red shoes. [The QP] contacted the non-emergency number again at 3:01 pm and requested to add the last known outfit to the silver alert. [The local police department] then contacted [the QP] at 3:10 pm to confirm that information. They communicated that their sergeant would have to be notified, and superiors would decide to add the

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information. [The responding officer] then contacted [the QP] back at 3:17 pm and communicated that they would not add the information to the alert because it sounded like he/she said they didn't want to redirect officers already operating on previously provided information. This was the outfit he was found in. ABC team continued to search the area into the night following additional contact via phone at 6:20 pm to [a second hospital] to determine if anyone had brought [client #1] to the location. This attempt was also unsuccessful. The following morning 8/11/22, [the QP] searched to see if [the local police department] had updated the silver alert with pictures or additional information. It had no updates. [The QP] then emailed an additional picture at 4:48 pm to [the responding officer]. [The QP] then went to [a local hospital] at 5:00 am to check if [client #1] had arrived at the hospital. No success. Again, [the QP] requested if any unknown people reside in [a local hospital] who may fit [client #1]'s description with no success. [The QP] re-entered the area to continue searching for [client #1], with other administrative team members joining after that. At 7:16 am, [the responding officer] replied to the email sent, saying they have it. At 7:22 am, [the QP] responded that [the responding officer] had not updated the profile as of yet. [The responding officer] replied at 7:28 am that the picture was submitted with the paperwork. [The QP] then received a phone call from [the responding officer] and informed me that all pictures provided were too small. [The QP] made provisions to provide the police with an updated picture to meet size needs. At 8:18 am, [the QP] communicated with [the CC]and provided all known information known at the time. [The RD] and [QP] communicated to provide updates at 9:07 am and continue searching the area. [The QP] sent an

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V 367	Continued From page 11 additional picture at 11:19 am to be added to the silver alert profile. At 12:24 pm, [the QP] received a call from the hospital that [client #1] was in the hospital and checked in at 11:49 pm 8/09/22. [The QP] and [RD] arrived at the hospital to confirm that [client #1] was there. ABC staff confirmed his identity and ABC and the hospital then began collaborating with the medication list, health history, and other pertinent information. [Client #1] is still at the hospital at this report's time and is expected to be discharged later today. -The provider determined that staff failed to comply with policy and procedures to ensure client safety. The provider responded by updating staff alert systems, currently in talks with the home's landlord to implement an outdoor camera system to assist with monitoring the home perimeter. Staff has been in-serviced regarding bed checks, room checks, and shift change responsibility. Both staff members were placed on a 30-day evaluation and written disciplinary action. The provider continues to provide additional staff supervision to assist staff with identifying times when extra support is necessary and appropriate based on client specifics and to ensure staff complies with all agency policies and procedures. The provider will contact DSS (Department of Social Services) to receive the report completed. Contact to be made 8/18/22. [A local hospital's staff] did make the provider aware of [client #1] communicating that '[a name] hit him with a broom' when [a local hospital's staff] informed [client #1] he would be discharged. The provider has no staff member named [a name], and the closest person to the name communicated by [a local hospital] that works in the home is [a name]. This staff member only works weekends and was not present at the time of the event. DSS did follow up, but the provider received no paperwork regarding the event. The	V 367		

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V 367	Continued From page 12	V 367		

provider contacted DSS to receive the report completed. The provider made contact on 8/18/22, and a message was left. The provider will make the information available once the report is completed. The provider has resubmitted the hospital discharge paperwork under the attached documents section in IRIS."

Interview on 9/1/22 with client #1 revealed:
-Client #1 spoke in a very soft voice
-Stated he wanted to live by himself
-Staff treated him fine. "They are funny. There is a blue car in the driveway."
-"I was in the living room and the cable box was next to the wall. The satellite was outside. I pay $69. I have a new partner for me. She's a nurse. Back in the window of my bedroom. Alarm. I pulled it off. I got out of my bed and met a guy with a silver car. He kicked me. His name was (spelled out) DAEEDUI JUI."
-Denied any staff harming him, hitting him or the other clients
-Stated the broom was at the driveway

Interview on 9/1/22 with the RD revealed:
-Client #1's windows had alarms on the outside now
-The facility also erected a motion sensor outside client #1's window
-Staff #1 and staff #2 were written up and retrained on bed checks, room checks, alarm checks and staff shift change
-The main focus of the facility on the day client #1 eloped from the facility was to locate him.
-A storm came through and knocked the cable out
-Client #1 got upset and was redirected to watch Roku instead
-Roku did not have the same channels as client #1 was used to watching

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-885	A. BUILDING: _____ B. WING _____	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARDEN HOME	3104 DARDEN ROAD 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 367	Continued From page 13 -Client #1 eventually calmed down and went to bed. -Staff #1 left the facility "as he is only there during peak hours (4pm to 9pm)" -Staff #2 came in from 4pm to 12am -Staff #3 came in at 11:30pm -Staff #2 and staff #3 failed to conduct bed checks as required -"The bed checks are to be done every 15 minutes and recorded every 30 minutes. They failed to do this." Interview on 9/1/22 with the QP revealed: -Had completed the facility's incident report -Had not addressed client #1's allegation of a staff hitting him with a broom -Would immediately add that information to the IRIS report	V 367		