

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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  An annual and complaint survey was completed on June 29, 2022. The complaint was unsubstantiated (Intake #NC00189701). A deficiency was cited.  This facility is licensed for the following survey 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 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	Staff was terminated because she would not comply with following the intervention of client's one BP as trained.  The QP has continue to update staff on any updates in the behavior plan.  The QP, House Manager and the Director has assist staff who are having difficulty consumers. Along with update training with staff on the consumer's current Behavior Plan. The QP will do on shift training and observation of staff on shift to make sure that they fully understand how to use proper intervention techniques.  The QP will determine if staff is following the BP . Staff will be terminate if they do use the training they were trained on with consumers  The QP will conduct followup training to all or any updates behavioral plan or consumer treatment plan with staff.  Qp will do a staff supervision on treatment plan if problems with consumers consistently occurs with one staff. The owner will evaluate, and meet with all team members to see if consumer is still in the appropiate level of care	5/31/2022  7/1/2022

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>owner/Director</b>	(X6) DATE <b>08/16/2022</b>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------	--------------------------------



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 2 Former Staff (FS #1) failed to implement goals and strategies of 1 of 3 client's (#1) Individual Behavior Support Plan (IBSP). The findings are:</p> <p>Review on 6/28/22 of FS #1's record revealed: -A hire date of 4/29/21 -A separation date of 5/31/22 -A job description of Paraprofessional -A certificate of client behavior plan training for client #1 noted "the goal of the plan, psychotherapeutic medications, client's target behaviors, historical information, structure, preventive and intervention procedures, documentation of collective data and behaviors and training strategies for relation/problem solving." -Training on data documentation, data tracking and data input for client #1 dated 5/13/21</p> <p>Review on 6/20/22 of client #1's record revealed: -An admission date of 9/1/15 -Diagnosis of Mild Intellectual Disability, Bipolar Disorder, Not Otherwise Specified, Attention Deficit Hyperactivity Disorder, Scoliosis, Constipation and Iron Deficiency -An assessment dated 9/1/15 noting "aged out of foster care, received her certificate from an education center and transitioned to [a local day program], previously hospitalized due to</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 112	<p>Continued From page 2</p> <p>elopements, refusing medications, refusing to bathe, smearing feces and barricading herself in her bedroom, has a history of stealing, has a history of verbal and physical aggression, engaged in severe property destruction, attempted to run into the street, history of hormonal instability, history of non-compliance, accusing other of doing things to her, a history of hoarding food and inserting herself into other's business."</p> <p>-A treatment plan dated 5/1/21 noting "will remain on task with an activity until complete, will manager her anger appropriately, will participate appropriately in a leisure/exercise activity of her choice 3 times per week, will improve her independence with completing daily chores, will be able to properly care for her clothes, will complete independence with daily hygiene/grooming, will reduce the number of elopements to zero and will have 24-hour supervision in order to maintain her placement."</p> <p>-An IBSP dated 3/14/22 noted "target behaviors included eloping, noncompliance, physical aggression towards others, aggression to property by damaging, throwing or breaking or attempting to damage objects, verbal aggression, accusing staff/others of doing something to her, stealing, hoarding food and historical behaviors of inserting herself into other's business and smearing feces. Goals included decreasing her eloping, decreasing her noncompliance, decreasing both physical and verbal aggression, decreasing accusing others, emptying her pockets when asked and decreasing hoarding of items ...intervention strategies included ...if she elopes or is physically aggressive and does not</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 112	<p>Continued From page 3</p> <p>want to calm down, call 911 for assistance, use blocking techniques to protect self and others, move objects and prompt others to get out of her way so she is less likely to damage them ..."</p> <p>Interview on 6/28/22 with FS #1 revealed: -Had recently quit her job at the group home (5/31/22) -Had been trained on client #1's IBSP -"With [client #1] it's like she expects staff to do everything for her. The last few days, she punched me in the face, continued to elope and she doesn't like to listen to the staff. It's hard working with her and working there. She always wants attention, gets up and leaves, and then I have to keep calling the police all the time ..." -The majority of her training was on what to do when client #1 eloped from the facility. -"[The Director] and [the Licensed Psychologist] told us (facility staff) everything we are supposed to do, every precaution to take and it still does not work as she will not listen and even when you try to prompt her and keep prompting her, I have to keep talking to her. [Client #1] will say she is sorry and then does the same thing ..." -Worked on 5/31/22 when client #1 eloped from the facility. -"I just told her if she left, I was calling the police. That's all I did. She doesn't listen ...I did not ask her to calm down. I have other clients to worry about ..." -Did not follow client #1's IBSP with asking her to calm down, used verbal prompts or used blocking techniques</p> <p>Observation and interview on 6/20/22 with client #1 at approximately 10:10am revealed: - Stated she had grits for breakfast -Her eyes are wide open and were not able to blink</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 112	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-Was drooling on left side of face, her arms/hands had uncontrollable tremors.</li> <li>-Like living here as staff were nice and the food was good.,</li> <li>-Admitted to running from the group home</li> <li>-"Go nowhere."</li> <li>-Shook head yes to sitting in the street and the police coming out to the facility.</li> <li>-"Not safe (in the street)."</li> <li>-Shook her head to the police returning her to the facility.</li> <li>-Stated she did not know why she runs away.</li> <li>-Started yelling to the House Manger " Come here. Come here."</li> <li>-No other information was able to be gathered as client #1 got up with assistance and went to her room.</li> </ul> <p>Reviews on 6/29/22 of the LP Specialized Consultative Services Service Notes, dated 6/1/22 and 6/7/22, for client #1 revealed</p> <p>-"6/1/22: Description of Intervention/Activity: Received a call from [client #1] Care Coordinator. She said [client #1] eloped last evening (5/31/22) and someone in the community found her. She was drooling, complaining about her stomach hurting and she need to go to the hospital. There was no staff around and the woman let her sit in the air-conditioned car and gave her water. She called 911 for assistance and the woman noted [client #1] was shaking and EMS transported [client #1] to the hospital ...people in the community said they had seen her walking alone in the community before ..."</p> <p>-"Plan of Action: will meet with [client #1] and/or her team approximately monthly to review progress and status. Will modify the behavior support plan as needed. Will train staff as requested and needed. Will summarize and analyze behavior data monthly ..."</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 112	<p>Continued From page 5</p> <p>-6/7/22: Description of Intervention Activity: Participate in a conference call with facility staff, the QP, The Director, the Care Coordinator and the Guardian Representative to discuss behaviors, interventions and updates since the last team meeting ..."</p> <p>Interview on 6/28/22 with the Licensed Psychologist (LP) revealed: -Was scheduled to retrain all the staff at the facility on 6/30/22 on client #1's IBSP -Had completed training with the staff on 6/7/22,</p> <p>Further interview on 6/29/22 with the LP revealed: -Would not be conducting the training on 6/30/22 -Client #1 was admitted to the hospital on 6/29/22 -The hospital was looking at placing her in a skilled nursing facility.</p> <p>Interview on 6/20/22 with the Qualified Professional revealed: -FS #1 was terminated on 5/31/22 -"She was not a good fit with working with [client #1]. She had been trained several times on [client #1]'s IBSP ...she would let [client #1] run off and then call the police. She knew her triggers and what behaviors to look for ..."</p> <p>Interview on 6/28/22 with the Director revealed: -All staff had been trained in client #1's IBSP -Terminated FS #1 on 5/31/22 -"She called [the House Manager] and said [client #1] had eloped. She had to be told to call 911 ..." -Was only recently made aware by the Local Management Entity/Managed Care Organization (LME/MCO)'s monitoring team that the police and EMS were called on 5/31/22 ..." -it was her understanding FS #1 just let her elope from the facility and did not use any of the strategies in her plan.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0411115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/29/2022</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>J GEE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 OLD JONES ROAD GREENSBORO, NC 27406</b>
----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 112	<p>Continued From page 6</p> <p>-In the future, she would ensure all staff have undated training on any clients' IBSP and understood what strategies to use.</p> <p>Further interview on 6/29/22 with the Director revealed:</p> <p>-Client #1 was taken to the hospital on 6/28/22</p> <p>-Was assessed and physically client #1 was cleared.</p> <p>-"The social worker at the hospital had her admitted. She is looking for a skilled nursing facility for [client #1]. Once that is done, I will complete her discharge summary. The social worker stated we were not equipped to assist her (client #1) anymore as she needed a higher level of care ..."</p>	V 112		