DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G248	A. BUILDING _____ B. WING _____	C 06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLINGSWOOD GROUP HOME	214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677

(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) COMPLETION DATE
W 000	INITIAL COMMENTS #NC00189877	W 000	W-149 -	
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: The facility failed to assure 1 of 6 clients in the group home (#1) was not neglected by staff resulting in the client leaving the group home unattended as evidenced by observation, interview and record verification. The finding is: Review on 6/13/22 of the facility's abuse/neglect investigations revealed an investigation dated 4/23/22 regarding client #1 and whether staff failed to provide the appropriate care for the client. Review of the investigation revealed the client left the group home unaccompanied by staff and around 4:00 PM the neighbor came to the group home to report that client #1 was in his yard. None of the 3 staff working were aware that client #1 had left the group home even though the client has required Line of Sight (LOS) supervision throughout the day. Further review of the investigation revealed the neighbor again returned to the group home at 7:00 PM to report that client #1 was again in his yard for a second time and that he was calling the police. Additional review of the investigation revealed that again staff were unaware that client #1 had left the group home until alerted by the neighbor. Interview with the neighbor by the facility	W 149	A fence was installed at the home in the front and the back Motions sensor will also installed by her bedroom. Extra alarms have been added to all doors leading outside In discussions about this situation it became clear that client #1 was very attracted to the neighbor's playhouse. A playhouse and outside toys will be purchased and set up for client #1 for her to use in her backyard. General level of supervision training will be completed for all staff at Client ! home by the Q. Specific LOS training will be completed with all staff as it relates to Client #1 by the Q. Policies and procedures that prohibit mistreatment, neglect or abuse of our residents will be reviewed with all staff in home meetings at least annually beginning in 2022.by clinical staff	7-31-22 8-5-22 Play house is install ed. 8-10-22 House meeting scheduled for 8-16-22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Ony — TITLE: Executive Director — (X6) DATE: 8-10-22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 investigator revealed client #1 was destroying his daughter's toys and trying to take them out of the house. He also revealed that the client was outside trying to take his Easter decorations and trying to get back into his house. The neighbor further stated that the client was in and out of his house for a total of 10 minutes altogether before he went next door. Continued review of the facility abuse/neglect investigations revealed another investigation regarding client #1 started 5/22/22 in which the client again left the group home at 7:00 PM without staff knowledge and went over to the neighbor's house. The neighbor again knocked on the door and this time returned the client himself to the home. The investigation further revealed the client was out of the home for 10 to 15 minutes. Review of both investigations, substantiated by interview with the Regional Vice President, revealed neglect was substantiated by the facility and 2 staff were terminated for not monitoring client #1 as required. In addition, other recommendations were implemented to assure the safety of client #1 including retraining staff, implementation of staff responsibility sign off sheets, door alarms, gate on the front porch, the purchase of additional leisure items for client #1 and the construction of a privacy fence and security fence around the home. Observations in the group home on 6/13/22 revealed a temporary gate to be in place on the front porch as well as door alarms on the outside doors and the client's bedroom. Further observations, substantiated by interview with the residential team leader (RTL) and Regional Vice	W 149		

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W 149	Continued From page 2 President, revealed the fences are not in place yet, but have been ordered. Review of the facility's Services Manual 102.052 defines neglect as "the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm." In addition, unintentional neglect is "defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk for harm." The facility failed to maintain the required LOS supervision required for the client on 3 occasions which resulted in the client leaving the group home unaccompanied and neglect of client #1.	W 149		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 2 investigations reviewed was completed and results were reported to the administrator within 5 working days relative to an allegation of neglect. The finding is: Review of facility documentation on 6/13/22 for client #1 revealed an internal neglect investigation dated 4/23/22 to determine if there was a delay in the implementation of interventions to prevent the client from leaving the premises unsupervised and undiscovered by staff. Further review of the 4/2022 internal investigation revealed client #1	W 156		

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W 156	Continued From page 3 left the premises on 4/23/22 at 4:00 PM and again at 7:00 PM and entered a neighbor's property and home. Interview with the neighbor revealed the client was in and out of his home for around 10 minutes before he walked over to the group home to report to staff that the client #1 was in his home. Continued review of the investigation revealed neglect was substantiated and resulted in the termination of a staff person. Subsequent review of the facility's investigation, substantiated by interview with the facility regional vice president (RVP) revealed the investigation was not completed until 5/9/22, which exceeded the 5-day reporting requirement. Review of the second internal investigation dated 5/22/22 revealed client #1 for a third time exited the group home undetected and unsupervised and again entered a neighbor's home. The neighbor this time, returned client #1 to staff and it was determined that the client was out of home for 10-15 minutes. Neglect was substantiated which resulted in the termination of a staff person and several additional safeguards to put into place. However, further review of this investigation, substantiated by further interview with the facility RVP, revealed the investigation did not conclude until 6/3/22, which again exceeded the 5-day reporting requirement.	W 156	W-156 - Reporting requirements for investigations and incidents will be reviewed with staff. Newly hired clinical staff will complete initial training and a review of abuse and neglect reporting will be completed annually with all clinical staff.	06-15-22 to 06-22-22