STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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, complaint and follow up survey was completed on 3/7/24. The complaint was substantiated (intake #NC213939). Deficiencies were cited. This facility is licensed for the following category:10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients.	V 000		
V 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	V 112 The Regional Administrator in-serviced all staff on client specific plan for client #1 regarding bathing. The in-service included using hand over hand and at no time to leave person supported in the bathroom alone. This in-service was completed 3/7/24. The clinical team will do routine unannounced visits in the home to ensure client #1 client specific plan during bathing is occurring. In the future the Qualified Professional will ensure staff are trained and follow clients' specific plans. By: 3/30/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julia Shaw — TITLE: Regional Administrator — (X6) DATE: 3/26/24

received by MHL & C 4/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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	Continued From page 1 This Rule is not met as evidenced by: Based on record review, and interviews the facility failed to implement treatment strategies for 1 of 3 clients (#1). The findings are: Review on 2/29/24 and 3/6/24 of client #1's record revealed: - Admission date: 2/2/2000 - Diagnoses: Anxiety Disorder; Autism; Profound Intellectual Disability; and Seizure Disorder - Review of client #1's treatment plan dated 3/1/23 revealed: "[client #1] is verbal but when asked a question he will make noises or express things that does not pertain to what is being asked ...[client #1] continues to need hand over hand and prompting when completing household chores and showering." Review on 3/6/24 of "RHA (Licensee) Incident Report" dated 10/14/23 revealed: - "Time of incident: 6:40 am - Description of incident and/or injury ...[client #1] was exiting shower and as he walked towards his room he slipped and fell, staff immediately responded and assisted [client #1] off the floor observing him for injury. Staff noticed swelling of the upper left arm. Staff contacted the nurse and followed procedure ... - Notifications. Nursing (notify immediately) [Nurse #9]; Date: 10/14/23; Time 6:55 am; Notified by [staff #3]	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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	Continued From page 2 - Signature of staff making report: [Staff #3]; Date: 10/14/23 - Nursing/Medical Review of Intervention ...Description of injury and treatment given: When he (client #1) fell getting out of the shower, he landed on his left upper arm right on the tub and broke his upper arm. Sent to ER (Emergency Room). - Signature of Nurse: [Nurse #10] Date: 11/6/23." - Note: Nurse #10 was not the nurse who was on-call on 10/14/23 but wrote the nursing note for the 10/14/23 level 1 incident report. Interview on 3/5/24 with the Nurse #9 revealed: - She was the on-call nurse on 10/14/23. - She was contacted by staff #3 on 10/14/23. - Staff #3 reported that client #1 "slipped and fell out of the shower." - She was not present when client #1 fell and was only told what occurred to client #1 by staff #3. - "I can just go by what is reported to me. I was not in the home. I would not think [client #1] would be given an unsupervised shower." Review on 3/1/24 of client #1's hospital record revealed: - "Arrival date & time: 10/14/23 1317 (1:17 pm) - Chief Complaint(s) Fall and Arm Injury (Left) ... - [Client #1] is a 53 y.o. (year old) male history of intellectual disability, seizure disorder, autism presenting with left arm pain. Patient slipped after getting out of shower this morning and was seen to have injured his left arm. There was an obvious deformity so he was brought to the emergency department. Caregivers have noticed he is not moving his arm as much. History otherwise limited as patient nonverbal." - Date: 11/2/23 - "FINDINGS: Seven fluoroscopic intraoperative radiographs demonstrate ORIF (Open Reduction	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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	Continued From page 3 Internal Fixation) of a a mid diaphyseal humeral fracture with an intramedullary rod with proximal and distal interlocking screws." Interview on 3/6/24 with client #1's Care Coordinator revealed: - Client #1 needed a staff member to assist him when taking a shower. - It states in his treatment plan that he continues to need "hand over hand when showering." Interview on 3/4/24 with staff #3 revealed: - Sometime in October 2023 "[client #1] was showering and I was checking on [client #2]. I hear the thump boom." When he came into the bathroom client #1 was on the floor. - He helped get client #1 off the floor. - "Then I noticed about 20 minutes later his (client #1's) whole arm turned really red and swollen so I called nursing immediately." Interview on 3/5/24 with the Qualified Professional revealed: - On 10/14/23, staff #3 told him that client #1 was getting out of the shower and that when he (client #1) fell. Staff #3 said that he gave client #1 a shower "because he used the bathroom on himself." Staff #3 "witnessed everything." Staff #3 did an incident report. - "[Client #1] needs assistance when taking a shower." Review on 3/7/24 of the Plan of Protection dated 3/7/24 written by the Vice-President revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The Regional Administrator will in-service all staff on the client specific plan for [client #1] during bathing. The in-service will include using hand over hand and at no time to leave person	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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	Continued From page 4 supported in the bathroom alone. Describe your plans to make sure the above happens. The in-service will be completed by 3/7/24 or before staff return to work from leave, PTO (paid time off) or illness." The facility served client #1 who had diagnoses of Anxiety Disorder, Autism, Profound Intellectual Disability, Seizure Disorder, and he was nonverbal. The facility staff did not follow the treatment plan for client #1 which included hand over hand and prompting when completing household chores and showering. On 10/14/23, Client #1 was in the shower without staff assistance and he fell and broke his upper left arm. Client #1's broken arm resulted in an Open Reduction Internal Fixation (ORIF) surgical procedure of a mid diaphyseal humeral fracture with placement of an intramedullary rod with proximal and distal interlocking screws. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either:	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 289	Continued From page 5 (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)	V 289	V 289 The following in-services were completed on 3/7/24: The Regional Vice President in-serviced the Qualified Professional on notification to guardians and Care Coordination on significant events and prompt notification and notifying the Regional Administrator and Vice President of any allegations of abuse/neglect/exploitation. RHA nursing staff were in-serviced by the Regional Vice President and Regional Administrator on ensuring people supported receive medical care in a timely manner and to notify the Regional Administrator immediately so arrangements for care can be provided. The Regional Administrator in-serviced all staff on not locking door within the home by any method to confine a person supported in their room and this would be considered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 289	Continued From page 6 (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to assure that residential services were provided to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a developmental disability or disabilities, and who require supervision when in the residence affecting 1 of 3 clients (#1). The findings are: Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on record reviews and interviews, the facility failed to coordinate services for 1 of 3 clients (#1). Cross Reference: 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V517). Based on record reviews and interviews, the facility failed to ensure that restrictive interventions were not used as a means of coercion, for the convenience of staff, or due to inadequacy of staffing affecting 1 of 3 clients (#1).	V 289	abuse. The Regional Administrator will monitor all Incidents Reports for timely notification and timely treatment. The clinical team will monitor through routine observations to ensure no bedroom or bathroom doors are locked. In the future the Qualified Professional will ensure all allegations of abuse/neglect/exploitation are investigated, timely reporting of significant events to guardians and Care Coordination and providing medical care to people supported in a timely manner. By: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 289	Continued From page 7 Review on 3/7/24 of the Plan of Protection dated 3/7/24 written by the Vice-President revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The Regional Vice President will in-service the Qualified Professional on informing guardians and Care Coordination of any significant events. This will include medical issues, bruises, significant behavior issues and allegations of abuse/neglect and exploitation. Follow up with guardians and Care Coordinators in a timely manner. The Regional Vice President will in-service the Qualified Professional on reporting procedures for abuse/neglect/exploitation. All allegations will be reported to the Regional Administrator and Vice President Immediately upon knowledge of the incident. The Regional Administrator and or the Regional Vice President will in-service all nursing staff on ensuring people supported receive medical care in a timely manner by transport from [Licensee] of EMS (Emergency Medical Services). If transportation cannot be found, they must notify the Regional Administrator immediately, so arrangements may be made. The Regional Administrator will provide in-service training to all staff on not locking any door within the home by any method to confine a person supported in their room and this is considered abuse. Describe your plans to make sure the above happens. All in-services and re-training will be completed by 3/7/24 or before staff return to work from leave, PTO (paid time off), or illness." The facility served client #1 with diagnoses of: anxiety disorder, Autism, Profound Intellectual Disability, Seizure Disorder, and he was	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 289	Continued From page 8 nonverbal. While getting out of the shower client #1 broke his arm and it took facility staff over 6 hours to get him to the hospital. In addition to having his upper left arm broken, client #1 had bruising to his right eyelid and bruising below his eye and was locked in his bedroom. His care coordinator was not notified by the facility about his broken arm, eye bruising nor was she notified that client #1 was locked in his bedroom. Client #1's legal guardian was not notified that he had eye bruising and was locked in his bedroom. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 289		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 9 Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to coordinate services for 1 of 3 clients (#1). The findings are: Finding #1 Review on 3/6/24 of "RHA (Licensee) Incident Report" dated 10/14/23 revealed: - "Time of incident: 6:40 am - Description of incident and/or injury ...[Client #1] was exiting shower and as he walked towards his room he slipped and fell, staff immediately responded and assisted [client #1] off the floor observing him for injury. Staff noticed swelling of the upper left arm. Staff contacted the nurse and followed procedure ... - Notifications. Nursing (notify immediately) [Nurse #9]; Date: 10/14/23; Time 6:55 am; Notified by [staff #3] - Signature of staff making report: [Staff #3]; Date: 10/14/23 - Nursing/Medical Review of Intervention ...Description of injury and treatment given: When he (client #1) fell getting out of the shower, he landed on his left upper arm right on the tub and	V 291	V 291 Cross Reference V289 V 366 The following in-services were completed on 3/7/24: The Regional Vice President in-serviced the Qualified Professional on notification to guardians and Care Coordination on significant events and prompt notification and notifying the Regional Administrator and Vice President of any allegations of abuse/neglect/exploitation. The Regional Administrator will in-service all Qualified Professional on Incident Reporting including what qualifies as a Level 2 or 3 incidents. It will also include appropriate documentation requirements and follow-up. The staff will be in-serviced on Incident Reporting and notifications. The Regional Administrator will monitor all Incident Reports to ensure all notifications, follow up and reporting of Level 2 and 3 Incident Reports. In the future the Qualified Professional will follow all policies and procedures related to Incident Reporting. guardians and Care Coordination and providing medical care to people supported in a timely manner. By: 4/20/24	

V 291
Cross Reference V289

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 10 broke his upper arm. Sent to ER (Emergency Room). Signature of Nurse: [Nurse #10] Date: 11/6/23." Review on 3/1/24 of client #1's hospital record revealed: - "Arrival date & time: 10/14/23 1317 (1:17 pm) - Chief Complaint(s) Fall and Arm Injury (Left) ... - "[Client #1] is a 53 y.o. (year old) male history of intellectual disability, seizure disorder, autism presenting with left arm pain. Patient slipped after getting out of shower this morning and was seen to have injured his left arm. There was an obvious deformity so he was brought to the emergency department. Caregivers have noticed he is not moving his arm as much. History otherwise limited as patient nonverbal." Review on 3/5/24 of screen shots of pictures provided by Nurse #9 originally taken on 10/14/23 revealed: - Picture of client #1's left arm was taken at 7:57 am on 10/14/23. Client #1's upper left arm appeared to be very swollen and his lower left arm appeared to be red. Attempted Interview on 3/1/24 with client #1 revealed: - Was unable to provide additional information. Attempted Interview on 3/1/24 with client #2 revealed: - Was unable to provide additional information. Attempted Interview on 3/1/24 with client #3 revealed: - Was unable to provide additional information. Interview on 3/4/24 with staff #3 revealed: - Sometime in October 2023 "[Client #1] was	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 11 showering and I was checking on [client #2]. I hear the thump boom." When he came into the bathroom client #1 was on the floor. - He helped get client #1 off the floor. - "Then I noticed about 20 minutes later his (client # 1's) whole arm turned really red and swollen so I called nursing immediately." Interview on 2/28/24 with Anonymous Staff #2 revealed: - She was fearful of termination if she talked to the "state" (Division of Health Service Regulation (DHSR)) about what occurred in the facility. - There was a scar on client #1's upper left arm. "A few months ago, he fell coming out of the shower." Client #1's fall occurred in October 2023 when staff #3 was working alone. - She came in "about 7 am" after the fall occurred. Staff #3 told her the fall occurred at 6 am which was before she came in on her shift. - When she went to change client #1, that was when she noticed the area between his shoulder and elbow looked like an "M. That's how bad it was broken." - "Nothing was done until 2 pm that afternoon." - When client #1 was taken to the hospital later that same day, it was confirmed the arm was broken. A month later client #1 had surgery and had a rod put in his arm. Interview on 3/1/24 with former staff (FS) #12 revealed: - Sometime possibly in October 2023, on a weekend, she arrived at the facility about 8:30 am. - "When I came in, I noticed something weird about him (client #1). He was kind of hunched walking." - When his shirt was off, "that's when I noticed his arm looked weird. His upper arm right above his	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 12 elbow and shoulder, it looked very wiggly." - I called RHA (Rehabilitation Health Associates) (Licensee) nursing (nurse #9) and she said to use an audio/video application when talking to her and she was going to come out (to the facility) anyway that day. I think she was getting ready when I called her. She took one look at it (client #1's arm) and said go to the ER (emergency room)." - She had been told by staff #3 that client #1 "slipped coming out of the shower that morning." Client #1 would have taken a shower sometime between 6 am - 7 am. - It took a longer period to get client #1 to the hospital because she waited on FS #13/former house manager to arrive at the facility. - She did not know why they did not call the ambulance to get client #1 to the hospital. Interview on 3/5/24 with Nurse #9 revealed: - On 10/14/23 she was on call and received a phone call at 6:55 am from staff #3. Staff #3 told her that client #1 slipped and fell out of the shower. Staff #3 reported client #3's arm was swelling. - At 10:45 am FS #12 reported that client #3's arm swelling was "worse." - "You would need to speak to staff about that (why it took so long to get client #1 to the hospital." I know that they are supposed to talk to the QP (Qualified Professional) about coordinating transportation and keeping staffing ratios." - "Personally, and I will say it like it is, it should not have taken that long (to get client #1 to the hospital)." Interview on 3/5/24 with the QP revealed: - On 10/14/23 when client #1 broke his arm he was not contacted when "it first happened."	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 13 - FS #12 was the first staff who told him about client #1's arm injury. FS #12 told him she had concerns and had talked to the nursing staff. He told FS #12 if client #1 needed to go to the emergency room to get back in touch with nursing. - Nursing was trying to "make arrangements" for transportation to the emergency room. - He then told former staff #13/former house manager to go out to the facility. - Staff #13/former house manager was delayed and he was normally the back up to go out to the facility if additional staff were needed. - "I could have taken him (client #1) (to the hospital)." Finding #2 Review on 3/6/24 of Level 1 incident report dated 10/14/23 revealed: - No documentation about Care Coordinator being contacted regarding 10/14/23 incident of client #1's broken arm. Review on 3/5/24 of untitled document written by the QP on 2/2/24 revealed: - There was no wording on the paperwork provided by the QP that indicated it was an incident report. - Beyond the QP's signature and date, the only information on the paper revealed: "On the morning of February1, 2024, the QP was informed by [staff #4] that [client #1] had a red mark under his eye. The QP then asked him if he was aware of what happened. [Staff #4] stated no and that this was the first time he saw it, while shaving him. The QP then contacted client #1's one-on-one (staff #1) to inquire. [Staff #1] stated that she had not seen a red mark under [client #1's] eye. The QP then contacted the 2nd shift	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 14 staff who also stated that they were not aware of a red mark by [client #1's] eye. When [client #1] arrived at the center, later that morning, the QP and nursing examined his eye. They did notice a red mark under his eye, but they had to pull back his eyelid in order to see it. They did not see any swelling. As a result, it was determined that no further investigation was warranted." - There was no documentation about notification to other professionals nor client #1's legal guardian. Observation and Interviews on 3/1/24 and 3/5/24 with Anonymous Staff #5 revealed: - Sometime soon after she started to work (1/8/24), "[staff #4] locked [client #1] in his bedroom." She assumed staff #4 did this "to calm him down." She and staff #4 were the only two staff who worked that day. - She had been cooking and noticed that she did not hear client #1 walking back and forth anymore. When she did not hear client #1 walking back and forth, she walked back to client #1's bedroom. She saw "something" on client #1's bedroom doorknob that she had not seen before. "I am not sure what type of lock it was it did not come with the door." She tried to open client #1's bedroom door and it would not open. Later client #1 did come out of his bedroom and she no longer saw the lock device on the doorknob. She never discussed the lock on client #1's bedroom door with staff #4 but did report the lock on client #1's bedroom door to the QP. - The QP had contacted her and asked her if she reported him to the DHSR. - On 3/5/24 at 1:19 pm anonymous staff #5 pointed to a picture of a metal doorknob cover that had a key lock. She reported what she saw on client #1's bedroom doorknob looked like the picture.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 15 - On 2/2/24 staff #4 reported bruising under client #1's eye to FS #11 (former house manager) and staff #4 stated it did not happen on his shift. Then the QP contacted her and asked her about the bruising to client #1's eye. She had told FS #11 and the QP that when she left on 2/1/24 at 9:30 pm client #1 had no eye bruising. On 2/3/24 she returned to work and took pictures of client #1's eye. - She also reported to the QP a red scrape on client #1's back side on 2/4/24 and sent a picture to the QP. - She told the QP that she had showered client #1 the day before (2/3/24) and had not seen the red scrape on his back side. - The QP told her that staff #1 (client #1's 1 on 1) had already sent him a picture of the red scrape on client #1's back. Review on 3/5/24 of a screen shot provided by anonymous staff #5 dated 2/3/24 revealed: - At the top of the screen shot was the QP's name. - The picture was taken of client #1's face. His right eye lid was dark purple and below his eye was a light purple mark pointing towards his nose and faded brown/yellow mark under his eye towards to middle part of his eye . - Anonymous staff #5 text to the QP under the picture: "Just want to make sure that how it is when I got here today." - The QP's response to Anonymous staff #5: "It's getting better." Review on 3/5/24 of a screen shot provided by anonymous staff #5 dated 2/4/24 revealed: - At the top of the screen shot was the QP's name. - The picture was taken of client #1's back in the bathtub. There was a red/purple scrape mark	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 16 that was in the shape of a backwards "J." The mark was below his shoulder blade and appeared to be at least 6 inches. - Anonymous staff #5 text to the QP under the picture: "That was on him yesterday on my shift cause I was the one to take him a shower" Interview on 3/4/24 with staff #4 revealed: - He had told the QP that client #1 had eye bruising to his eye about "2-3 weeks ago." - "I took a picture and sent it to [QP]." - He told the QP it did not happen on his shift. Review on 3/4/24 of a screen shot provided by staff #4 dated 2/1/24 revealed: - At the top of the screen shot was the QP's name. - The picture was taken of client #1's face. Client #1 appeared to have shaving cream on his face in the picture. Client #1 had the same bruising to his eye in the picture as seen in screen shot provided by anonymous staff #5. Please see "review on 3/5/24" of screen shot for description of client #1's eye bruising. - Staff #4's text to the QP under the picture: "I didn't see a report on it when I came in." Interview on 3/4/24 with FS #11 revealed: - She had been the house manager since 10/30/23 and resigned 2/27/24. - Anonymous Staff #5 told her about the bruising on client #1's eye and the red scrape on client #1's back about 1-2 weeks prior to the QP doing an in-service about abuse and neglect. The anonymous staff also shared pictures of the injuries. - She talked to the QP about the bruising to client #1's eye and the red scrape on client #1's back. Interview on 3/6/24 with Nurse #10 revealed:	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 17 - On 2/1/24 she was made aware of client #1's black eye. "I think [staff #1] brought [client #1] to nursing." - She took a picture of client #1's eye and sent it to the RHA doctor. The doctor ordered that ice be applied to client #1's eye and give him Tylenol. - "I think the scrape (one client #1's back) was shown to me nearly the same time as the black eye." Interview on 3/4/24 with Client #1's Care Coordinator revealed: - She never received notification from the facility staff about the 10/14/23 incident regarding client #1's broken arm. She found out about client 1's broken arm through client #1's legal guardian. - After she talked to client #1's legal guardian about the broken arm she contacted the QP and "told him that any time there is an incident with [client #1] we need to be notified as a team." - She was not notified by the facility that client #1 had a black eye and large red scratch on his back (2/1/24). - She was also not notified by the facility that client #1 had been locked in his bedroom. Interview on 3/6/24 with Client #1's Legal Guardian revealed: - He was not notified by the facility that client #1 had a black eye and large red scratch on his back (2/1/24). - He was also not notified by the facility that client #1 had been locked in his bedroom nor bathroom. Interview on 3/5/24 with the QP revealed: - He was told by staff #4 that client #1 had bruising under his eye on 2/1/24. - He called client #1's legal guardian and left him a message about the eye bruising. "It was a	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 291	Continued From page 18 couple days after the bruising was discovered. I don't know the exact date." - No one notified him about the scrape on client #1's back. "I didn't get a text about the scrape on his back." - He did not notify client #1's care coordinator on 10/14/23 when client #1 broke his arm. He was not sure when he reported client #1's broken arm to his care coordinator. - Client #1 could not have been locked up in his bedroom. "Someone, [anonymous staff #5] said something about [client #1] being locked up in a room. She said he had been locked in the bathroom because there were no locks on his bedroom door." - Anonymous staff #5 told him that it was staff #4 who locked client #1 in his bedroom. - "She (anonymous staff #5) did not give a lot of details because she was new and didn't want to cause a lot of confusion." - He did in-service training with staff about locking up clients the next day. He was unable to provide the in-service training paperwork. - He did not report client #1 being locked in his bedroom/bathroom to client #1's legal guardian nor his care coordinator. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 291		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 366	Continued From page 19 shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team;	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 366	Continued From page 20 (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if	V 366	V 366 The following in-services were completed on 3/7/24: The Regional Vice President in-serviced the Qualified Professional on notification to guardians and Care Coordination on significant events and prompt notification and notifying the Regional Administrator and Vice President of any allegations of abuse/neglect/exploitation. The Regional Administrator will in-service all Qualified Professional on Incident Reporting including what qualifies as a Level 2 or 3 incidents. It will also include appropriate documentation requirements and follow-up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 366	Continued From page 21 different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews, the facility falled to implement written policies governing their response to level II incidents as required. The findings are: Finding #1 Review on 3/6/24 of "RHA (Licensee) Incident Report" dated 10/14/23 revealed: - "Time of incident: 6:40 am - Description of incident and/or injury ...[Client #1] was exiting shower and as he walked towards his room he slipped and fell, staff immediately responded and assisted [client #1] off the floor observing him for injury. Staff noticed swelling of the upper left arm. Staff contacted the nurse and followed procedure ... - Notifications. Nursing (notify immediately) [Nurse #9]; Date: 10/14/23; Time 6:55 am; Notified by [staff #3] - Signature of staff making report: [Staff #3]; Date: 10/14/23 - Nursing/Medical Review of Intervention	V 366	The staff will be in-serviced on Incident Reporting and notifications. The Regional Administrator will monitor all Incident Reports to ensure all notifications, follow up and reporting of Level 2 and 3 Incident Reports. In the future the Qualified Professional will follow all policies and procedures related to Incident Reporting. By;4/20/24 V 367 Cross Reference V 366	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 366	Continued From page 22 ...Description of injury and treatment given: When he (client #1) fell getting out of the shower, he landed on his left upper arm right on the tub and broke his upper arm. Sent to ER (Emergency Room). - Signature of Nurse: [Nurse #10] Date: 11/6/23." Interview on 3/5/24 with the Qualified Professional (QP) revealed: - He did not determine the cause of the incident; and he did not develop and implement corrective measures; he did not develop and implement measures to prevent similar incidents; he did not assign persons to be responsible for implementation of the corrections and preventative measures. - Had not notified client #1's care coordinator about the injury. Finding #2 Interviews on 3/5/24 and 3/6/24 with the QP revealed: - Client #1 could not have been locked up in his bedroom. "Someone, [anonymous staff #5] said something about [client #1] being locked up in a room. She said he had been locked in the bathroom because there were no locks on his bedroom door." - Anonymous staff #5 told him that it was staff #4 who locked client #1 in his bedroom. - "She (anonymous staff #5) did not give a lot of details because she was new and didn't want to cause a lot of confusion." - He did in-service training with staff about locking up clients the next day. He was unable to provide the in-service training paperwork. - He talked to staff #4 and anonymous staff #5 about client #1 being locked up but had no written documentation.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 366	Continued From page 23 -Did not have documentation regarding attending to the health and safety needs of the client involved in the incident; he did not determine the cause of the incident; and he did not develop and implement corrective measures; he did not develop and implement measures to prevent similar incidents; he did not assign persons to be responsible for implementation of the corrections and preventative measures. - Had not notified Legal Guardians and other authorities required by law. Finding #3 Review on 3/5/24 of a screen shot provided by anonymous staff #5 dated 2/4/24 revealed: - At the top of the screen shot was the QP's name. - The picture was taken of client #1's back in the bathtub. There was a red/purple scrape mark that was in the shape of a backwards "J." The mark was below his shoulder blade and appeared to be at least 6 inches. - Anonymous staff #5 text to the QP under the picture: "That was on him yesterday on my shift cause I was the one to take him a shower" Interview on 3/4/24 with FS #11 revealed: - She had been the house manager since 10/30/23 and resigned 2/27/24. - Anonymous Staff #5 told her about the bruising on client #1's eye and the red scrape on client #1's back about 1-2 weeks prior to the QP doing an in-service about abuse and neglect. The anonymous staff also shared pictures of the injuries. - She talked to the QP about the bruising to client #1's eye and the red scrape on client #1's back. Review on 3/5/24 of untitled document written by	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 366	Continued From page 24 the QP on 2/2/24 revealed: - There was no wording on the paperwork provided by the QP that indicated it was an incident report. - Beyond the QP signature and date the only information on the paper stated: "On the morning of February1, 2024, the QP was informed by [staff #4] that [client #1] had a red mark under his eye. The QP then asked him if he was aware of what happened. [Staff #4] stated no and that this was the first time he saw it, while shaving him. The QP then contacted client #1's one-on-one (staff #1) to inquire. [Staff #1] stated that she had not seen a red mark under [client #1's] eye. The QP then contacted the 2nd shift staff who also stated that they were not aware of a red mark by [client #1's] eye. When [client #1] arrived at the center, later that morning, the QP and nursing examined his eye. They did notice a red mark under his eye, but they had to pull back his eyelid in order to see it. They did not see any swelling. As a result, it was determined that no further investigation was warranted." Interview on 3/5/24 with the QP revealed: -He did not determine the cause of the incident; and he did not develop and implement corrective measures; he did not develop and implement measures to prevent similar incidents; he did not assign persons to be responsible for implementation of the corrections and preventative measures. - Had not notified Legal Guardians and other authorities required by law.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 25 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 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:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 26 (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 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.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 27 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to submit Level II incident report to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 2/28/24 of the NC Incident Response Improvement System (IRIS) revealed: - There were no incident reports regarding: client #1's broken arm, client #1's bruised eye and red/purple scrape on his back, nor client #1 being locked in his bedroom/bathroom. Interview on 3/7/24 with IRIS staff revealed: - Client #1's unexplained eye bruising should have been submitted as a level 2 IRIS report. Interview on 3/5/24 with the Qualified Professional revealed: - He was responsible for completing IRIS reports for the facility. - He did not complete an IRIS report regarding client #1's eye bruising. - He did not complete an IRIS report when client #1 broke his arm. "I am not for sure (why the report is not in IRIS)." - He did not complete an IRIS incident report regarding client #1 being locked up in the bedroom/bathroom. - After client #1 was locked in his bedroom he told staff during in-service regarding locking up clients, "anytime anything is done like that we're supposed to do an incident report."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record observations, and interviews, the facility failed to provide services using the least restrictive and most appropriate methods affecting 3 of 3 client (#1- #3). The findings are: Observations at approximately 10:24 am on 3/5/24 of the kitchen doors revealed: - Observed kitchen door on the left side of the	V 513	V 513 A Team Meeting will be held with the guardian and Care Coordination to discuss the locks on the kitchen doors for client # 1. Per the Team Meeting results, all consents for restrictions will be obtained from all guardians and HRC members for all people supported. The HRC will monitor all rights restrictions every 90 days to ensure the least restrictive interventions are implemented. in the future the Qualified Professional will ensure methods for providing services or the least restrictive and most appropriate. By: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 513	Continued From page 29 kitchen from the den area to have a child proof door handle cover. - Observed the 2nd door to the kitchen from the hallway to have a keyed lock on the door. - The keyed lock/child proof door handle cover were on the only two doors that went into the kitchen from the interior of the facility. Interview on 3/5/24 with the QP revealed: - The lock and child proof door handle cover were on the kitchen doors to prevent client #1 from going into the kitchen because "he runs into the kitchen and grabs food."	V 513		
V 517	27E .0104(c-d) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse. (d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure that restrictive interventions were not used as a means of coercion, for the convenience of staff,	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 517	Continued From page 30 or due to inadequacy of staffing affecting 1 of 3 clients (#1). The findings are: Review on 3/7/24 of the facility's seclusion policy revealed: - "Restraint Procedures: [the Licensee] does not allow the use of seclusion or isolation Time Out." - "Prohibited Procedures: Seclusion, defined as placing a person in a locked room for the purpose of controlling their behavior." Observation and Interviews on 3/1/24 and 3/5/24 with Anonymous Staff #5 revealed: - Sometime soon after she started to work (1/8/24), "[staff #4] locked [client #1] in his bedroom." She assumed staff #4 did this "to calm him down." She and staff #4 were the only two staff who worked that day. - She had been cooking and noticed that she did not hear client #1 walking back and forth anymore. When she did not hear client #1 walking back and forth, she walked back to client #1's bedroom. She saw "something" on client #1's bedroom doorknob that she had not seen before. "I am not sure what type of lock it was it did not come with the door." She tried to open client #1's bedroom door and it would not open. Later client #1 did come out of his bedroom and she no longer saw the lock device on the doorknob. She never discussed the lock on client #1's bedroom door with staff #4 but did report the lock on client #1's bedroom door to the Qualified Professional (QP). - On 3/5/24 at 1:19 pm staff #5 pointed out to the DHSR Surveyor a picture of a metal doorknob cover that had a key lock. She reported what she saw on client #1's bedroom doorknob looked like the picture shown to her in an internet search. Interviews on 3/5/24 and 3/6/24 with the QP	V 517	V 517 The following in-services were completed on 3/7/24: The Regional Vice President in-serviced the Qualified Professional on notification to guardians and Care Coordination on significant events and prompt notification and notifying the Regional Administrator and Vice President of any allegations of abuse/neglect/exploitation. The Regional Administrator in-serviced all staff on not locking door within the home by any method to confine a person supported in their room and this would be considered abuse. The Regional Administrator will monitor all Incidents Reports for timely notification and timely	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 517	Continued From page 31 revealed: - Client #1 could not have been locked up in his bedroom. "Someone, [anonymous staff #5] said something about [client #1] being locked up in a room. She said he had been locked in the bathroom because there were no locks on his bedroom door." - Anonymous staff #5 told him that it was staff #4 who locked client #1 in his bedroom. - "She (anonymous staff #5) did not give a lot of details because she was new and didn't want to cause a lot of confusion." - He did in-service training with staff about locking up clients the next day. He was unable to provide the in-service training paperwork. Interview on 3/4/24 with staff #4 revealed: - Denied that he locked client #1 in his bedroom. - "I have not put any locks on his (client #1) bedroom door." Attempted Interview on 3/1/24 with client #1 revealed: - Was unable to provide additional information. Attempted Interview on 3/1/24 with client #2 revealed: - Was unable to provide additional information. Attempted Interview on 3/1/24 with client #3 revealed: - Was unable to provide additional information. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 517	treatment. The clinical team will monitor through routine observations to ensure no bedroom or bathroom doors are locked. In the future the Qualified Professional will ensure all allegations of abuse/neglect/exploitation are investigated and staff are trained to use the least restrictive interventions. By: 4/20/24	
V 736	27G .0303(c) Facility and Grounds Maintenance	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 736	Continued From page 32 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on interview and observation, the facility was not maintained in a safe, attractive, and orderly manner. The findings are: Observation of the facility's interior on 3/5/24 between 10:46 am and 10:48 am revealed: Kitchen: -Worn areas revealed rust in microwave, 1 area about 1 inch and several smaller areas around rim, as well as 3-4 spots of rust on the inside Hallway bathroom: -The entire bottom of the bathroom door had peeling/splintering wood. -At the entrance of the hallway bathroom approximately 6-8 inches of the vinyl flooring was peeling. Interview with the Qualified Professional on 3/7/24 revealed: - Microwave was "not old at all, about a year old ...recently bought a new one, (it's) less than 2 years old." - "Rust was how we ended up replacing the last one because the health department saw rust and it was replaced." - "No one has said anything about it and I haven't checked the microwave." - "I've never paid attention to that (bathroom door) ... Had not seen it (peeling/splintering wood), we will have to let the owner know." - "I put in a work order the other day (to address the vinyl floor in the bathroom), ...maintenance	V 736	V 736 The microwave has been replaced. A contractor has been hired to repair the door and vinyl flooring in the bathroom. The clinical team will monitor through routine observations and monthly Environmental Assessments to ensure all items are repaired/replaced and in good working order. In the future the Qualified Professional will ensure all locations are safe, attractive and in good repair. By: 5/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-561	A. BUILDING: _____ B. WING _____	R 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

(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 736	Continued From page 33 said he would take a look at it."	V 736		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 21, 2024

Shelia Shaw, Regional Administrator
RHA Health Services NC, LLC
1701 Westchester Drive, Suite 940
High Point, North Carolina 27262

Re: Annual, Complaint, Follow up Survey completed March 7, 2024
Three Meadows 2103 Three Meadows Road, Greensboro, NC 27455
MHL # 041-561
E-mail Address: sshaw@rhanet.org
Intake #NC00213939

Dear Ms. Shaw:

Thank you for the cooperation and courtesy extended during the annual, complaint, and follow up survey completed March 7, 2024. The complaint was substantiated.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112).
- Type B rule violation is cited for 10A NCAC 27G .5601 Scope (V289).
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A1 violations must be ***corrected*** within 23 days from the exit date of the survey, which is March 30, 2024. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against RHA Health Services NC, LLC for each day the deficiency remains out of compliance.
- Type B violations and all cross referenced citations must be ***corrected*** within 45 days from the exit date of the survey, which is April 21, 2024. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed deficiency by the 45th day from the date of the survey may result in the assessment of an administrative penalty of $200.00 (Two Hundred) against RHA Health Services NC, LLC for each day the deficiency remains out of compliance.

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is May 6, 2024.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Maria Smith at 828-747-9913.

Sincerely,

Angela Keadle

Angela C. Keadle, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

La-Ferne Harris
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Sharon Barlow, Director, Guilford County DSS
Joy Futrell, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Supervisor

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
MHL041-561	A. Building B. Wing	3/7/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE MEADOWS	2103 THREE MEADOWS ROAD GREENSBORO, NC 27455

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0108 Reg. # 27G .0202 (F-I) LSC	Correction Completed 03/07/2024	ID Prefix V0536 Reg. # 27E .0107 LSC	Correction Completed 03/07/2024	ID Prefix V0537 Reg. # 27E .0108 LSC	Correction Completed 03/07/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Angela Keaton	DATE 3/7/24
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO