STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411151	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKS HOUSE OF CARE	2611 ZOLA DRIVE GREENSBORO, NC 27405

(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 follow up survey was completed on June 6, 2024. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105	**II. Policy** All persons supported by Hicks House of Care shall have a permanent client record upon admission. The homes will have a client home record also upon entering the residential facility. The record shall have all information that is required by federal, state, and local authorities. All pages within the permanent client record must contain the clients name record number and Medicaid number. **III. Procedures:** A permanent client record shall be maintained for each client admitted to Hicks House of Care, The record shall contain but need not be limited to the following items. The home client home record book will contain a variation of the items listed below: Client profile containing: a. Name (last, first, middle, & maiden) b. Client Record Number c. Date of Birth d. Race, gender, and marital status e. Admission Date	

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105	f. Discharge Date g. Medicaid number Documentation of mental illness, developmental disabilities, or substance abuse diagnosis according to DSM IV. Documentation of screening and assessment. . Treatment/habilitation or Service plan, including any revisions/updates Authorizations Cost Summary Attendance Emergency information should by updated, as needed, and should contain the name, address, and telephone number of the person to be contacted in case of sudden illness or accident and the name address and telephone number of the client's preferred physician Consent for emergency treatment, that is less than one year old, must be maintained. This must be signed by the client or the legally responsible person Documentation of the services being provided . Documentation of progress toward outcomes For those clients without a formal behavior plan, any behaviors which may warrant consideration for a behavior plan, any behaviors documented on the Informal Behavior Data Form.	

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to implement their policy of record accessibility to authorized users at all times. The findings are: Observation on 6/5/24 at 9:33am of the clients' records revealed: -No client records were on the facility's premise. Review on 6/5/24 of the facility's "client record management" policy revealed: -"Purpose: the objective of this policy is to meet requirements relating to client records as set forth by the NCAC 27G. 0206. This policy applies to all locations operated by or under the supervision of Hicks House of Care, LLC." -"Policy: all individuals served shall have a record developed upon admission ...records are always accessible to authorized users, including direct care staff." Interview on 6/5/24 with staff #1 revealed: -"We do not have any client records here (at the facility). He (Owner/Qualified Professional (O/QP)) still keeps all of that with him." Interview on 6/5/24 with staff #2 revealed: -"Client records are kept by [O/QP]. He works third shift and will bring them back (to the facility) then." Interview on 6/6/24 with the O/QP revealed: -The facility staff "don't momentarily have access to the clients' records. I take their records over during my shift (3rd) and when I leave afterwards, I take the clients' records with me."	V 105	If applicable, the following documentation should also be included in the record: a. Documentation of physical disorders according to ICD-9-CM; b. Medication orders. c. Copies of lab test and orders for test. d. The Medication Administration Record. e. Medication Error Reports; and f. Any adverse Drug Reactions. All information relating to AIDS or related conditions will be held in the strictest confidence. This information will only be disclosed according to communicable disease laws as specified in G.S. 130A-143. DHHS Incident and Death Report form is filed in a separate locked file cabine When records are needed to be transported between agency or treatment locations, Hicks House of Care staff/provider will transport them in accordance with HIPPA regulations. When records are transported by motor vehicle, they shall be secured in a locked compartment, when not in use. .All records, including client home record, shall be secured under at least one lock. Information will only be shared with persons authorized to obtain information. Only pertinent information will be released. All information released will be documented in the release and disclosure log, along with the reason for release.	

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V 105	Continued From page 3 -"From now on, I will leave the clients' records at the facility and only take the grids with me when I leave." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 105	Records will be maintained for not less than twenty years from the time-of-service provision. The following staff may document the service record, Habilitation technician, Clinical staff, Therapeutic provider, day Center Coordinator, President, Vice President, and Residential Coordinator. Designated professional staff from the referring agency (DSS or Area Mental Health) may also document in the service record. To ensure the permanent records are properly managed the following will apply. The safeguard records against loss, tampering, defacement or use by unauthorized person: **Records will be stored in the administrative office in a locked location, such as a file cabinet or closet.** **All staff will have access to the records , authorized persons: the supervisor, Clinical Professional, management and/or area authorities; DHSR** **Records can be accessed through the assigned Clinical Professional, with proper documentation of authorization of release/disclosure.**	

Division of Health Service Regulation

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V 105	Continued From page 3	V 105	Clients may access their records with the assistance of the assigned Clinical Professional or a member of management; and if a client request for an alternation in their record the following procedure must be followed: clinical staff must be present when record is reviewed; if Clinical staff agrees with alteration, then addendum is added to contested part of record. But original part of record cannot be removed if Clinical staff does not agree then statement from legally responsible person is placed in record and released any time contested part of record is released. To assure that confidentiality is maintained, the above list of polices will be strictly enforced and information will only be released when proper consent for release/disclosure is obtained. **The agency failed to have client records accessible to authorized users.** **To ensure the client's records ore onsite and are properly secured** **The QA will store all client and personnel records in a locked location,** **Such as a file cabinet and/or closet.**	

Derrick Hicks QP
7-6-2024