

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2026
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NAME OF PROVIDER OR SUPPLIER QUALITY CARE III, LLC/HICKORY TREE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4010 HICKORY TREE LANE GREENSBORO, NC 27406
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V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on 1/9/26. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>The facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <ol style="list-style-type: none"> (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. <p>(b) In addition to the requirements set forth in</p>	V 366		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 366	<p>Continued From page 1</p> <p>Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(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:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p>	V 366		

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V 366	<p>Continued From page 2</p> <p>(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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to level I, II, or III incidents. The findings are:</p>	V 366		

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V 366	<p>Continued From page 3</p> <p>Review on 1/8/26 of client #1's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 5/15/18 - Diagnoses of Traumatic Brain Injury and Dementia - An "After Visit Summary" from a hospital emergency department which reflected client #1 was seen at the hospital on 11/23/25 after a "fall." - Diagnoses with a "contusion of the scalp" and a "urinary tract infection associated with indwelling urethral catheter." - Imaging tests were completed which included but not limited to the following: "...cervical spine without contrast; CT (Computed Tomography) head without contrast" and imaging of his right elbow and right shoulder - Was administered Rocephin (an antibiotic) 1 gm (gram) injection while at the hospital <p>Interview on 1/8/26 with client #1 revealed:</p> <ul style="list-style-type: none"> - Had fallen at the facility and injured his head - Was transported by Emergency Medical Services (EMS) personnel to a hospital emergency department for treatment - Could not recall the date or any other specifics related to his fall and/or treatment at the hospital <p>Review on 1/8/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - No level II incident report had been submitted to IRIS regarding client #1 and the events of 11/23/25 <p>Interview on 1/8/26 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> - She thought she had submitted an incident report to IRIS regarding the events of 11/23/25; however, she could not be sure - Would check her records to see if she had 	V 366		

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V 366	Continued From page 4 submitted an incident report to IRIS and inform the surveyor on 1/9/26 Interview on 1/9/26 with the QP revealed: - She had failed to submit a level II incident report to IRIS regarding client #1's fall and his EMS transport to a hospital emergency department on 11/23/25 - Client #1 was administered the Rocephin to treat his urinary tract infection - He returned to the facility on 11/23/25 - Although it was late, she had now completed an incident report and submitted it to IRIS - As there had been no level II incident report completed prior to 1/9/26, there was no documentation to support how client #1's health and safety needs were being attended to; a determination of the cause of the incident; what corrective measures were developed and implemented to prevent similar incidents and what person(s) were assigned to be responsible for implementation of any corrective and preventative measures which were all a part of a level II incident report	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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V 367	<p>Continued From page 5</p> <p>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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 6</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a level II incidents to the Local Management Entity (LME) responsible for the</p>	V 367		

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V 367	<p>Continued From page 7</p> <p>catchment area where services were provided within 72 hours of becoming aware of the incident affecting 1 of 3 clients (client #1). The findings are:</p> <p>Review on 1/8/26 of client #1's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 5/15/18 - Diagnoses of Traumatic Brain Injury and Dementia - An "After Visit Summary" from a hospital emergency department which reflected client #1 was seen at the hospital on 11/23/25 after a "fall." - Diagnoses with a "contusion of the scalp" and a "urinary tract infection associated with indwelling urethral catheter." - Imaging tests were completed which included but not limited to the following: "...cervical spine without contrast; CT (Computed Tomography) head without contrast" and imaging of his right elbow and right shoulder - Was administered Rocephin (antibiotic) 1 gm (gram) injection while at the hospital <p>Interview on 1/8/26 with client #1 revealed:</p> <ul style="list-style-type: none"> - Had fallen at the facility and injured his head - Was transported by Emergency Medical Services (EMS) personnel to a hospital emergency department for treatment - Could not recall the date or any other specifics related to his fall and/or treatment at the hospital <p>Review on 1/8/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - No level II incident report had been submitted to IRIS regarding client #1 and the events of 11/23/25 <p>Interview on 1/8/26 with the Qualified Professional (QP) revealed:</p>	V 367		

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V 367	<p>Continued From page 8</p> <ul style="list-style-type: none"> - She thought she had submitted an incident report to IRIS regarding the events of 11/23/25; however, she could not be sure - Would check her records to see if she had submitted an incident report to IRIS and inform the surveyor on 1/9/26 <p>Interview on 1/9/26 with the QP revealed:</p> <ul style="list-style-type: none"> - She had failed to submit a level II incident report to IRIS regarding client #1's fall and his transport by EMS to a hospital emergency department on 11/23/25 - Client #1 was administered the Rocephin to treat his urinary tract infection and he returned to the facility on 11/23/25 - Although it was late, she had now completed a level II incident report and submitted it to IRIS 	V 367		