STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 4/3/18. The complaint was substantiated (Intake # NC00136515). Deficiencies were cited. This facility is licensed is licensed for the following service categories: 10A NCAC 27G.5400 Day Activity for Individuals of All Disability Groups. 10A NCAC 27G.5100 Community Respite Services for Individuals of All Disability Groups.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).	V 132		

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V 132	Continued From page 1 Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide protection to the clients from harm during an investigation of abuse and failed to notify the Department of all allegations against health care personnel. The findings are: Review on 3/15/18 of Client #1's record revealed: -Admission 4/1/11 -35 years old -Diagnoses included Schizoaffective Disorder, Attention Deficit Disorder, Mild Mental Retardation, Personality Disorder, Anxiety and Impulse Control Disorder. Review on 3/19/18 of Staff #1's employee record revealed: -Date of hire 4/13/17 -Job title: Paraprofessional Interview on 3/16/18 and 3/21/18 with Client #1	V 132		

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V 132	Continued From page 2 revealed: -Staff #1 had "punched" him; he described this as hitting on his chest with an open hand. -Staff #1 had kissed him on the forehead, and grabbed him in the groin area, one time. - He could not remember the date this occurred, but he told Staff #1 to "back off" and he did. -Staff #1 gave him religious compact discs (CDs) a couple of weeks ago and told him he had a premonition Client #1 was going to hell. -He just tried to stay away from Staff #1 as he made him uncomfortable. Interview on 3/16/18 and 3/20/18 with Client #1's Alternative Family Living (AFL) provider revealed: -In January 2018 she observed Staff #1 tickling, poking, grabbing the client in the stomach, and kissing him on the forehead. She observed Staff #1's hand go down to Client #1's groin area two times, outside of his clothes. -Staff #1's hand "pushed in ...like cupped, squeezed" Client #1's private parts, twice. -Client #1 yelled "stop it, quit it, leave me the f**k alone!" -She reported this to her Qualified Professional (QP) on 2/23/18. -On 3/5/18 as soon as she picked up Client #1 after the day activity center he told her Staff #1 gave him three religious CDs even though she was told by the QP at the day activity center Staff #1 would have no further contact with the client. -Client #1 told her Staff #1 then said, "If you don't change your actions toward me - I'm innocent." Observation on 3/21/18 at 5:30 p.m. of three CDs revealed: -All three CDs were from a local church. -Two had a recording date of 2/25/18 titled "Don't Get Mad at the Mirror" and "The Call to Carry the Cross."	V 132		

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V 132	Continued From page 3 -A third CD dated 3/4/18 was titled "Are you Salty Enough?" Interview on 3/19/18 with the QP for Client #1's AFL provider revealed: -She was told on 2/27/18 Staff #1 was observed being verbally inappropriate with Client #1, teasing him, kissing him on the forehead and touching him on his groin. -She verbally reported the allegation to the Quality Assurance (QA) Director and had no further involvement with the allegation. Interview on 3/15/18 with the Clinical Director of the day activity center revealed: -She was notified by the QP of the allegation on 3/2/18. -Staff #1 had not worked one-on-one with Client #1 since 2/19/18 and once the allegation was received Staff #1 was told not to have any contact with Client #1. Interview on 3/19/18 with the QA Director revealed: -It was reported to him "last week" by the QP of the AFL provider that sometime last year, Staff #1 inappropriately touched Client #1 outside of his clothes in the groin area and had tickled the client. -He called the QP and Clinical Director at the day activity center and asked them to interview Client #1 and Staff #1 about the allegation. -He called the Executive Director once he learned of the allegation and was told to take Staff #1 off his route and for him not to work with Client #1. -Staff #1 continued to work at the day activity center in a group setting where there was always more than one staff present. -Staff #1 admitted to kissing and tickling Client #1 and had been counseled on that.	V 132		

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V 132	Continued From page 4 -He did not report the allegation to the department because he wanted to make sure it was legitimate and did not want to defame Staff#1's character. -He felt he could not get any accuracy on the situation, and it was the state, the LME, or the local DSS to determine if it was substantiated or not. -He was aware the individuals making the allegation did not like Staff #1 and he did not want to ruin his career over an inappropriate comment. -He was not convinced the abuse occurred, so he did not report the allegation to the department. Interview on 3/22/18 and 4/3/18 with the Executive Director revealed: -She was notified of the allegation against Staff #1 on 3/5/18. -She was told Staff #1 was sticking his hands between Client #1's legs, and grabbing his private area. -She called the QA Director who said he would talk to the QP at the day activity center. -She also notified the QA Director to take Staff #1 off transport as this was where he would be one-on-one with clients. -Staff #1 continued to work at the day activity center, however he only worked in a group setting where there were always other staff present. -He was told not to transport any clients, and not to assist any clients to the bathroom until the investigation was complete. -The QA Director handled all the investigations, incident reporting and any follow-up needed. -She felt the clients were protected during the investigation as Staff #1 was kept in a class room type setting where there were numerous staff present. This deficiency is cross referenced into 10A	V 132		

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V 132	Continued From page 5 NCAC 27D.0304(a) Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
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 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:	V 367		

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V 367	Continued From page 6 (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: (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;	V 367		

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V 367	Continued From page 7 (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. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report Level III incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 3/15/18 of Client #1's record revealed: -Admission 4/1/11 -35 years old -Diagnoses included Schizoaffective Disorder, Attention Deficit Disorder, Mild Mental Retardation, Personality Disorder, Anxiety and Impulse Control Disorder. Interview on 3/16/18 and 3/21/18 with Client #1 revealed: -Staff #1 had "punched" him; he described this as hitting on his chest with an open hand. -Staff #1 had kissed him on the forehead, and grabbed him in the groin area, one time. - He could not remember the date this occurred, but he told Staff #1 to "back off" and he did. -He just tried to staff away from Staff #1 as he made him uncomfortable. Interview on 3/16/18 and 3/20/18 with Client #1's	V 367		

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V 367	Continued From page 8 Alternative Family Living (AFL) provider revealed: -In January 2018 she observed Staff #1 tickling, poking, grabbing the client in the stomach, and kissing him on the forehead. She observed Staff #1's hand go down to Client #1's groin area two times, outside of his clothes. -Staff #1's hand "pushed in ...like cupped, squeezed" Client #1's private parts, twice. -Client #1 yelled "stop it, quit it, leave me the f**k alone!" -She reported this to her Qualified Professional (QP) on 2/23/18. Interview on 3/19/18 with the QP for Client #1's AFL provider revealed: -She was told on 2/27/18 Staff #1 was observed being verbally inappropriate with Client #1, teasing him, kissing him on the forehead and touching him on his groin. -She verbally reported the allegation to the Quality Assurance (QA) Director and had no further involvement with the allegation. Interview on 3/19/18 with the QA Director revealed: -It was reported to him "last week" by the QP of the AFL provider that sometime last year, Staff #1 inappropriately touched Client #1 outside of his clothes in the groin area and had tickled the client. -He did not report the allegation to the department because he wanted to make sure it was legitimate and did not want to defame Staff#1's character. -He felt he could not get any accuracy on the situation, and it was the state, the LME, or the local DSS to determine if it was substantiated or not. -He was aware the individuals making the allegation did not like Staff #1 and he did not want	V 367		

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V 367	Continued From page 9 to ruin his career over an inappropriate comment. -He was not convinced the abuse occurred, so he did not report the allegation to the department. Interview on 3/22/18 and 4/3/18 with the Executive Director revealed: -She was notified of the allegation against Staff #1 on 3/5/18. -The QA Director handled all the investigations, incident reporting and any follow-up needed.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

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V 512	Continued From page 10 This Rule is not met as evidenced by: Based on observations, interviews and record review one of three staff (Staff #1) subjected one of 4 clients (Client #1) to serious abuse and 2 of 2 staff (Quality Assurance Director and Executive Director) failed to protect clients during the investigation. The findings are: Cross Reference: General Statue 131E-256(g) - Health Care Personnel Registry (V132) Based on interviews and record review the facility failed to provide protection to the clients from harm during an investigation of abuse and failed to notify the Department of all allegations against health care personnel. Review on 3/15/18 of Client #1's record revealed: -Admission 4/1/11 -35 years old -Diagnoses included Schizoaffective Disorder, Attention Deficit Disorder, Mild Mental Retardation, Personality Disorder, Anxiety and Impulse Control Disorder. Interview on 3/16/18 and 3/21/18 with Client #1 revealed: -Staff #1 used to be his one-on-one worker at the day activity center. -Staff #1 had "punched" him; he described this as hitting on his chest with an open hand. -Staff #1 had kissed him on the forehead, and grabbed him in the groin area, one time. -He could not remember the date this occurred, but he told Staff #1 to "back off" and he did. -Staff #1 did some "unorthodox things" like when he got him out of the wheelchair he would say, "Now hug me like you love me." -He had not told anyone at the day activity center as he did not want to get in trouble and said, "I pray to God this don't back fire on me."	V 512		

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V 512	Continued From page 11 -Staff #1 gave him religious compact discs (CDs) a couple of weeks ago and told him he had a premonition that Client #1 was going to hell. -He just tried to stay away from Staff #1 as he made him uncomfortable. Interview on 3/16/18 and 3/20/18 with Client #1's Alternative Family Living (AFL) provider revealed: -In January 2018 Staff #1 arrived in a wheelchair lift van to pick Client #1 up for his day activity program. -Client #1 was in a bad mood; she observed Staff #1 tickling, poking, grabbing the client in the stomach, and kissing him on the forehead. -She observed Staff #1's hand go down to Client #1's groin area two times, outside of his clothes. -Staff #1's hand "pushed in ...like cupped, squeezed" Client #1's private parts, twice. -Client #1 yelled "stop it, quit it, leave me the f**k alone!" -She reported this to her Qualified Professional (QP) on 2/23/18. -On 3/5/18 as soon as she picked up Client #1 after the day activity center he told her Staff #1 gave him three religious CDs even though she was told by the QP at the day activity center Staff #1 would have no further contact with the client. -Client #1 was mad and said Staff #1 told him he had a premonition and he saw Client #1's body; his lower body, from the waist down was in hell, and his upper body was in heaven. -Client #1 told her Staff #1 then said, "If you don't change your actions toward me - I'm innocent." Observation on 3/21/18 at 5:30 p.m. of three CDs revealed: -All three CDs were from a local church. -Two had a recording date of 2/25/18 titled "Don't Get Mad at the Mirror" and "The Call to Carry the Cross."	V 512		

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V 512	Continued From page 12 -A third CD dated 3/4/18 was titled "Are you Salty Enough?" Interview on 3/20/18 with AFL provider of an unrelated client revealed: -She was present in the parking lot in January 2018 and remembered the interactions between Client #1 and Staff #1. -She observed Staff #1's hands "all over" Client #1, leaning over him while touching his chest and stomach, as he was getting Client #1 ready to put on the van lift. -She also heard a kissing or popping sound from Staff #1, but she did not actually see him kiss Client #1. Interview on 3/19/18 with the QP for Client #1's AFL provider revealed: -She was told on 2/27/18 Staff #1 was observed being verbally inappropriate, teasing him, kissing him on the forehead and touching him on his groin. -She felt Staff #1 was trying to get Client #1 in a better mood, but this was just going to make him madder. -She verbally reported the allegation to the Quality Assurance (QA) Director and had no further involvement with the allegation. Interview on 3/21/18 with the local Department of Social Services revealed: -Client #1 was interviewed twice by her and a co-worker and both times his story was consistent. -He stated Staff #1 had kissed him on the forehead and touched his private area. Interview on 3/21/18 with Client #1's guardian revealed: -Client #1 told her Staff #1 was punching,	V 512		

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(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 512	Continued From page 13 grabbing, hugging and kissing him. -He said it made him "uncomfortable." -Staff #1 "slapped his gonads ...that is exactly what he said ...he does not want that 'pervert' around him." -Staff #1 had not worked one-on-one with the client since 2/19/18, however she was concerned as Staff #1 continued to work with other clients at the day activity center. Review on 3/19/18 of Staff #1's employee record revealed: -Date of hire 4/13/17 -Job title: Paraprofessional Review on 3/19/18 of Staff #1's Monthly and Annual Supervision/Performance Evaluation notes revealed: -8/19/17 - Staff #1 improved on setting boundaries; what humor was appropriate and what was not. -9/26/17 - Staff #1 "needs to make sure that he is being a professional at all times by not crossing the line like tickling the individuals." -10/24/17 - Staff #1 "had improved on making his humor with the individual more professional." Interview on 3/15/18 and 3/22/18 with the QP for the day activity center revealed: -In early March 2018 he received a call from the agency's QA Director notifying him of an allegation of Staff #1 inappropriately touching Client #1 in the genital area. -The QA Director asked him and the Clinical Director to conduct interviews of Staff #1 and Client #1 for the internal investigation. -Client #1 denied the allegation. -Staff #1 denied the allegation. -The allegation was determined to be unsubstantiated.	V 512		

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	MHL011-247	A. BUILDING: _____ B. WING _____	04/03/2018

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V 512	Continued From page 14 -Staff #1 was never suspended during the investigation. -Staff #1 had been assigned to Client #1 as his one-on-one worker since he was hired in April 2017. -Staff #1 had not worked one-on-one or transported Client #1 since 2/19/18 due to him being assigned to another client. -He felt Client #1 was "making up stuff" because he was mad Staff #1 was no longer assigned to him. -Staff #1 was not alone with clients, he worked with clients as a group with other co-workers. -Client #1 would be present in these groups as well, while Staff #1 continued to work with others. -He confirmed the supervision notes above for Staff #1 were referencing interactions with Client #1. -He was unaware Staff #1 gave Client #1 religious CDs on 3/5/18. Interview on 3/15/18 with the Clinical Director of the day activity center revealed: -She was notified by the QP of the allegation on 3/2/18. -She and the QP were in charge of interviewing Client #1 and Staff #1. -Client #1 said Staff #1 tapped him on the head to get his attention; joked with him and he did not like it. -Client #1 did not say Staff #1 touched him inappropriately. -Staff #1 denied touching Client #1 inappropriately. -Staff #1 had not worked one-on-one with Client #1 since 2/19/18 and once the allegation was received Staff #1 was told not to have any contact with Client #1. -She had not received any complaints of Staff #1 until this allegation.	V 512		

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V 512	Continued From page 15 Interview on 3/19/18 with the QA Director revealed: -It was reported to him "last week" by the QP of the AFL provider that sometime last year, Staff #1 inappropriately touched Client #1 outside of his clothes in the groin area and had tickled the client. -He called the QP and Clinical Director at the day activity center and asked them to interview Client #1 and Staff #1 about the allegation. -He called the Executive Director once he learned of the allegation and was told to take Staff #1 off his route and not to work with Client #1. -Staff #1 continued to work at the day activity center in a group setting where there was always more than one staff present. -He took a statement from the unrelated AFL provider who said Staff #1 tickled and kissed Client #1 on the forehead. -Staff #1 admitted to kissing and tickling Client #1 and had been counseled on that. -He did not report the allegation to the department because he wanted to make sure it was legitimate and did not want to defame Staff#1's character. -He felt he could not get any accuracy on the situation, and it was the state, the LME, or the local DSS to determine if it was substantiated or not. -He was aware the individuals making the allegation did not like Staff #1 and he did not want to ruin his career over an inappropriate comment. -He was not convinced the abuse occurred, so he did not report the allegation to the department. Review on 3/19/18 of the statements taken by the QA Director revealed: -Statements from witnesses were initiated on 3/1/18 and the last statement was dated 3/6/18.	V 512		

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V 512	Continued From page 16 -Statements collected were similar to interviews conducted during the survey. Interview on 3/22/18 and 4/3/18 with the Executive Director revealed: -She was notified of the allegation against Staff #1 on 3/5/18. -She was told Staff #1 was sticking his hands between Client #1's legs, and grabbing his private area. -She called the QA Director who said he would talk to the QP at the day activity center. -She also notified the QA Director to take Staff #1 off transport as this was where he would be one-on-one with clients. -Staff #1 continued to work at the day activity center, however he only worked in a group setting where there were always other staff present. -He was told not to transport any clients, and not to assist any clients to the bathroom until the investigation was complete. -The QA Director handled all the investigations, incident reporting and any follow-up needed. -She felt the clients were protected during the investigation as Staff #1 was kept in a class room type setting where there were numerous staff present. -She spoke to the QP of the day activity center, who was Staff #1's direct supervisor, and was told he had been talking with Staff #1 about boundaries, and Staff #1 was definitely in need of more training. Review on 3/22/18 of the Plan of Protection dated 3/22/18 written by the Executive Director revealed: What immediate action will the facility take to ensure the safety of the consumers in your care?	V 512		

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V 512	Continued From page 17 "1. Suspended accused staff pending investigation as of 3/23/18. 2. Reviewed and made changes to our policy 10A NCAC 27D.0304 Protection from Harm, Abuse, Neglect, Exploitation on 3/23/18. Added procedure relating to periodic staff and day program staff to include suspension. See attachment. 3. The staff who made the complaint ...has been directed by her supervisor to submit and incident report with the details of the alleged abuse or neglect, as was indicated by the Davidson Family Services [licensee] training for her on 5/24/16. Completion within 24 hours." Describe your plans to make sure the above happens. "4. Administrative leadership discussed on 3/23/18 the importance of following the rules related to G.S. 131E-256(g) to the agency submitting Incident Reports into IRIS. 5. Re-training staff on therapeutic relationship and boundaries. Training on this topic will be ongoing agency wide. 6. The staff who made the complaint ...will participate in a supervision session by the end of next week (3/30/18) with her direct supervisor and will be retrained on the requirement to submit incidents within 24 hours. 7. Upon receipt of this incident report the Davidson Family Services' Quality Assurance Department will enter the above-mentioned incident report into the State IRIS system. 8. Davidson Family Services will brief/train all staff on the importance of completing all incidents within 24 hours, as it pertains to 10A NCAC 27D.0304. This briefing/training (initially provided during orientation) includes the types of occurrences that should be reporter- including	V 512		

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V 512	Continued From page 18	V 512		

abuse, neglect or exploitation - as well as available options for reporting - including in-person, over the phone and/or 24 -hour anonymous hotline (see attached policy). Briefing/training will be completed by May 31st, 2018."

Review on 3/22/18 of the attachments to the Plan of Protection revealed:

"Davidson Family Services Policies ...Client Rights Protection from Harm, Abuse, Neglect, Exploitation ...Procedure for Periodic Staff and/Day Program
(a) when a report or accusation of harm, abuse, neglect, and exploitation occurs, the accused staff shall be immediately suspend from providing services to the individual and also to others.
(b) the suspension will last during the investigation period until resolution occurs.
(c) Davidson Family Services shall make the determination whether the employee is eligible to return to work.
(d) Davidson Family Services shall submit the incident report into the state IRIS system within 24 hours and a report to DSS within 5 days.
(e) Davidson Family Services shall complete an internal investigation."

"Corporate Compliance ...Davidson Homes maintains 24/7 telephone support ...The telephone number of the caller is kept anonymous ...All cases are reported to Davidson Homes' Corporate Compliance Office within 24 hours of receiving the call. It is the policy of DHI that no retaliation will be initiated against person who reports in good faith a suspected Fraud, Waste and Abuse ..."

An allegation of sexual abuse by Staff #1 was

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V 512	Continued From page 19 reported to the licensee on 2/27/18. It was alleged that the reporter witnessed Staff #1 touching Client #1 in the groin area, outside his pants, two times. It was also alleged Staff #1 was observed tickling the client, rubbing his chest, and kissing him on the forehead. The day activity center, where Staff #1 worked, was not notified of the allegation until 3/2/18. Staff #1 had been counseled by his supervisor in August and September of 2017 on setting boundaries, appropriate use of humor, being professional, and to not tickle Client #1. Despite verbal instructions to stay away from Client #1 during the abuse investigation, Staff #1 was assigned to work at the day activity center in the presence of Client #1, sometimes working in the same group with Client #1. In addition, on 3/5/18, Client #1 reported an incident where Staff #1 had given him three religious CDs and made intimidating remarks to him, suggesting Client #1 was going to hell because Staff #1 was innocent. This deficiency constitutes a Type A1 rule violation for abuse and must be corrected within 23 days. An administrative penalty of $6,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		