ResCare
Residential Services

Community Alternatives North Carolina
1200 Navaho Drive
Raleigh, NC 27609
919.387.1011
fax: 919.387.1130
www.ResCare.com

April 13, 2018

Kimberly McCaskill, MSW
Facility Survey Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction for Complaint Survey Conducted April 6-9, 2018
Stonegate, 8609 Stonegate Drive, Raleigh, NC 27615
Provider Number: 34G293
MHL Number: MHL-092-137

Dear Mrs. McCaskill,

Thank you for your time and the feedback given during the survey you completed on April 6-9, 2018. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 238. Again, thank you for your time and patience.

Sincerely,

Jason Peace, MSW
Executive Director, CANC

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 13, 2018

Mr. Jason Peace, Executive Director
Community Alternatives, Inc. of NC
1001 Navaho Drive, Suite 101
Raleigh, North Carolina 27609

Re: Complaint Investigation Survey April 6, 2018-April 9, 2018
Stonegate, 8609 Stonegate Drive, Raleigh, NC 27615
Provider Number #34G293
MHL# 092-137
E-mail Address: jason.peace@rescare.com
Complaint Intake #NC00137438

Dear Mr. Peace:

Thank you for the cooperation and courtesy extended during the complaint investigation survey completed on April 9, 2018.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 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 and what to include in the Plan of Correction.

Type of Deficiencies Found

- Condition Level deficiencies are cited for §483.410 Governing Body and Management (W102), §483.420 Client Protections (W122).
- Standard level deficiencies were cited.

Time Frames for Compliance

- The condition level deficiencies must be ***corrected*** within 45 days from the exit date of the survey, which is **May 24, 2018**. You must request in writing a revisit indicating credible allegation of compliance no later than 45 days following the survey.
- If the facility is not in compliance at the time of the follow-up 45th day a recommendation for termination from the Medicaid program will be made effective within ninety (90) days from the last date surveyed.
-

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
WWW.NCDHHS.GOV
TEL 919-855-3795 • FAX 919-715-8078
LOCATION: 1800 UMSTEAD DRIVE •WILLIAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

- Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed condition level deficiencies by the 45th day from the date of the survey may result in the assessment of an administrative penalty of $400.00 (Four Hundred) against **Stonegate** for each day the deficiency remains uncorrected.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **June 8, 2018.**

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 CMS-2567 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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Kimberly McCaskill at (919)218-9152.

Sincerely,

Kimberly C. McCaskill

Kimberly C. McCaskill, MSW
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

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STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Governing Body and Management failed to: exercise general policy, budget, and operating direction over the facility (W104). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Governing body and management failed to exercise general policy, budget, and operating direction over the facility by failing to ensure allegations of abuse were thoroughly investigated, direct care staff reported inappropriate behavior by clients and unauthorized absences by staff providing coverage were reported to management in the facility. The findings are: 1. Direct Care Staff failed to consistently report to management inappropriate behavior by consumers for whom they were responsible.	W 104	Please refer to pages 2-3.	

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

Executive Director | 4/27/18

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

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W 104	Continued From page 1 Review on 4/9/18 of an investigation dated 2/10/18 revealed a direct care staff reported to management staff that client #2 reported to him that former client #4 inappropriately touched clients #2 and #1 in the genital area. Statements were taken from several staff in the facility and clients #1, #2 and #4 were interviewed. After reviewing the statements the investigative team determined these allegations were unsubstantiated as client #4 was hospitalized during the time frame client #2 alleged that these events took place. Interview on 4/6/18 with the Residential Manager via phone indicated after this investigation she instructed direct care staff to be aware of client #4's location every 15 minutes when he was in the home. She also instructed staff to be certain the door alarms above former client #4 and client #2's bedroom doors were operational. She additionally stated she told direct care staff to report any interactions between clients that was inappropriate. She stated during the last week in March 2018 (uncertain of specific date) a direct care staff reported to her client #2 reported former client #4 had inappropriately touched him. She stated former client #4 had been hospitalized and the time frame client #2 provided to direct care staff did not seem possible, so she chose not to investigate these allegations. Interview on 4/6/18 with staff #1 revealed he had witnessed former client #4 going into client #2's bedroom and on one occasion, he had shut the bedroom door. He did not report this inappropriate interaction to management staff. Interview on 4/6/18 with staff #2 revealed he had seen former client #4 go into client #1's bedroom	W 104	This condition will be corrected by the following actions: A. All Behavioral Support Plans (BSP) will be reviewed by the Qualified Professional and/or Psychologist to ensure that all identified maladpative behaviors are current and included in the plan. B. If needed, all BSPs will be revised by the Psychologist to include all identified maladpative behaviors. Once revised and consents obtained, the Qualified Professional will train all staff on all BSPs and appropriate interventions. C. Program Manager will provide staff with formal training on abuse and neglect, as well as client's rights. This training will include but not be limited to abuse, neglect, exploitation, client's rights, privacy. D. Program Manager will provide training to all staff related to proper reporting procedures, time frames, and on call procedures. E. Program Manager, with the assistance of maintainence, will purchase and install door alarms that will minimize the potential of being disarmed by residents. F. Qualified Professional will review and train all employees on how to implement daily procedures for ensuring alarms are properly working during each shift and what to do and who to contact when they are not working properly. Procedure will also include how to document daily alarm checks. Qualified Professional will be responsible for providing this training.	5/24/18

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W 104	Continued From page 2 and touch his face and ears. He stated this was not reported to management staff. Additional interview on 4/9/18 with the Residential Manager revealed she was not aware of former client #4 entering client #1 or #2's bedrooms. She stated direct care staff had not reported this to her. She stated on at least one occasion in March 2018 she had entered the facility and observed the door alarms over clients #2 and former client #4's bedroom doors had been disabled. She stated when asked, direct care staff reported they had not disabled these door alarms. She stated former client #4 was tall in stature and would have been able to deactivate these alarms. The Residential Manager stated she did not report this to management. She did instruct staff to be aware of these door alarms and to be certain during their assigned shifts the alarms were operational. Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of allegations involving former client #4 and client #2 that were given to the Residential Manager in March 2018. He stated he was also unaware of allegations of former client #4 entering the bedroom areas of clients #1, #2. He was also unaware the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. 2. Direct Care staff failed to consistently notify management staff when they did not report to work as scheduled. Interview on 4/9/18 with a direct care staff revealed she had been told by a coworker that on a Monday in February 2018 on second shift one	W 104	continued from page 2. G. Program Manager will train management personnel regarding proper staffing ratios and scheduling practices. Scheduling practices will include, but not limited to schedule submisison, daily/ weekly labor reviews, and reporting practices. H. Qualifed Profoessional will train all staff on Rescare attendance policies and expectations. Qualifed Professional will ensure that all staff how the proper contact information for all levels of management. I. Residential Manager and Qualified Professional will monitor and document adherence all corrective measures daily for a month. Afterwards, they will each provide on-going monintoring 3x/weekly. J. Program Manager will monitor and document adherence to all corrective measures weekly for a month. Afterwards, Program Manager will provide on-going monitoring bi-weekly.	5/24/18

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W 104	Continued From page 3 of two assigned direct care staff did not report to work as scheduled. She stated direct care staff reported he had driven to the vocational center, picked up the clients and taken them back to the facility. He stated he worked alone for the entire second shift without notifying management staff. Direct care staff stated this was not the only incident when staff did not report to work as scheduled without notifying management staff. Interview on 4/9/18 with the Qualified Professional (QP) and Residential Manager (RM) revealed they were not aware of any incident when staff did not report to work as scheduled and did not notify management staff.	W 104	Please refer to pages 2 and 3.	
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: implement policies intended to prohibit possible abuse of clients (W149) and thoroughly investigate allegations of abuse that affected 1 of 6 clients in the home (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122	For citataion W122, please refer to corrections listed for W149 and W154.	
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit	W 149		

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W 149	Continued From page 4 mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement policies intended to prohibit mistreatment or abuse of clients. This affected 3 of 6 clients in the home (#1, #2, #4). The finding is: Facility Management neglected to implement policies intended to prevent abuse of clients in the home. Review on 4/6/18 of client #2's record revealed an individual program plan (IPP) dated 5/18/17. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disabilities and Schizophrenia (Undifferentiated type). The IPP indicated client #2 had been adjudicated incompetent and had a guardian of the person appointed to act on his behalf. Additional review of his IPP revealed "Will have a privacy goal implemented as needed. He has no issues with maintaining his privacy or the privacy of others at this time." Review on 4/6/18 of former client #4's record revealed an IPP dated 1/30/18. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disability, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder, Episodic Mood Disorder, Pervasive Developmental Disorder. Further review of this IPP revealed a behavior support plan dated 3/19/18 to address target behaviors of Physical Aggression and Property Destruction. Review on 4/9/18 of an investigation dated	W 149	This condition will be corrected by the following actions: A. All Behavioral Support Plans (BSP) will be reviewed by the Qualified Professional and/or Psychologist to ensure that all identified maladpative behaviors are current and included in the plan. B. If needed, all BSPs will be revised by the Psychologist to include all identified maladpative behaviors. Once revised and consents obtained, the Qualified Professional will train all staff on all BSPs and appropriate interventions. C. Program Manager will provide staff with formal training on abuse and neglect, as well as client's rights. This training will include but not be limited to, abuse, neglect, exploitation, client's rights, privacy. D. Program Manager, with the assistance of maintainence, will purchase and install door alarms that will minimize the potential of being disarmed by residents. The implementation of alarms will provide an additional level of monitoring consumer movements. E. Qualified Professional will review and train all employees on how to implement daily procedures for ensuring alarms are properly working during each shift and what to do and who to contact when they are not working properly. Procedure will also include how to document daily alarm checks. Qualified Professional will be responsible for providing this training. D. Qualified Professional will provide training to all staff regarding the purpose and proper implementation documentation of bed checks.If needed, Qualified Professional will inccrease frequency of bed checks in order to provide more frequent visual checks. E. Residential Manager and Qualified Professional will monitor and document adherence all corrective measures daily for a month. Afterwards, they will each provide on-going monintoring 3x/weekly. F. Program Manager will monitor and document adherence to all corrective measures weekly for a month. Afterwards, Program Manager will provide on-going monitoring bi-weekly.	5/24/18

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W 149	Continued From page 5 2/10/18 revealed a direct care staff reported to management staff that client #2 reported to him that former client #4 inappropriately touched clients #2 and #1 in the genital area. Statements were taken from several staff in the facility and clients #1, #2 and #4 were interviewed. After reviewing the statements the investigative team determined these allegations were unsubstantiated as client #4 was hospitalized during the time frame client #2 alleged that these events took place. Review on 4/9/18 of a note by staff revealed former client #4 was physically aggressive towards staff and exhibited suicidal ideations on 3/27/18. Direct Care staff contacted the Police Department and former client #4 was hospitalized on 3/27/18. Interview on 4/6/18 with the Residential Manager via phone indicated after this investigation dated 2/10/18 she instructed direct care staff to be aware of client #4's location every 15 minutes when he was in the home. She also instructed staff to be certain the door alarms above former client #2 and client #4's bedroom doors were operational. She explained that she told direct care staff to report any interaction between clients that was inappropriate. She stated during the last week in March 2018 (uncertain of specific date) a direct care staff reported to her client #2 told him former client #4 had inappropriately touched him. She stated former client #4 had been hospitalized on 3/27/18 and the time frame client #2 provided to direct care staff did not seem possible, so she chose not to investigate these allegations. Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed former	W 149	For citataions W149, please refer to page 5.	

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W 149	Continued From page 6 client #4 was hospitalized and probably would not be re admitted to the facility when he is discharged. Alternative placement is being pursued by the hospital. Interview on 4/6/18 at the vocational center with client #2 revealed former client #4 had inappropriately touched him in the genital area with his mouth about two weeks ago. He stated former client #4 came into his bedroom at night, shut the door, pulled down his pants and kissed his genital area with his mouth. He stated former client #4 then left his bedroom, shutting the door behind him. When asked if this was witnessed by his roommate (who is not interviewable) or by the 2 direct care staff working in the facility, he stated, "No." It should be noted client #2 was crying during this interview and afterwards he vomited into a trash can in the room where he was being interviewed. This interview was also witnessed by the vocational staff who works with him as a Qualified Professional (QP). Additional interviews on 4/6/18 with client #5 and #6 revealed no inappropriate touching by other clients or staff. Clients #1 and #3 were not interviewable. Interview on 4/6/18 with former client #4 at the hospital revealed he had no knowledge of any clients entering other clients bedrooms without their consent. He stated he had never entered clients #1 and #2's bedrooms. He stated client #2 had come to his bedroom after he invited him to come and play a video game with him. He stated client #2 sat on his bed and watched him play a video game. He denied ever touching any of the clients in the facility. He asked this surveyor, "Who would tell you I went into their bedrooms?"	W 149	For citataions W149, please refer to pages 5.	

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W 149	Continued From page 7 This interview was witnessed by former client #4's therapist at the hospital. Interview on 4/6/18 with staff #A revealed he had witnessed former client #4 going into client #2's bedroom and on one occasion, he had shut the bedroom door. He did not report this inappropriate interaction to management staff. Interview on 4/6/18 with staff #B revealed he had seen former client #4 go into client #1's bedroom and touch his face and ears. He stated this was not reported to management staff. He also stated when he was working in March, he was in the hallway bathroom assisting client #1 with undressing when former client #4 walked into the bathroom. He stated when former client #4 realized staff #B was in the bathroom with client #1, former client #4 quickly exited the hallway bathroom. Staff #B did not report this to management. Additional interview on 4/9/18 with the Residential Manager revealed she was not told by direct care staff of former client #4 entering the bedroom areas of client #1 and client #2. She stated sometime during the month of March 2018 she noted when she came into her shift in the facility that the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. She stated she did not report this but instructed direct care staff to be aware of these alarms while they were working in the facility. Review on 4/9/18 of the facility policy regarding Abuse and Neglect page C.4.5 revealed "Any incidents of abuse or neglect are to be reported and investigated immediately, and according to	W 149	For citataions W149, please refer to pages 5.	

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W 149	Continued From page 8 prescribed procedures." Sexual Abuse is defined as "Any physical or provocative advances, such as caressing, fondling, sexual contact , sexual intercourse, etc. Encouraging a person to participate in nonconsensual sexual activity. Encouraging or allowing a person to be in any form of undress or to participate in sexual activity for the gratification of staff or other persons." Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of allegations involving former client #4 and client #2 that were given to the Residential Manager in March 2018. He stated he was also unaware of allegations of former client #4 entering the bedroom areas of clients #1, #2. He was also unaware the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. Additional interview revealed the facility policy regarding Abuse and neglect is current and should be implemented. Interview on 4/9/18 with the Operations Manager revealed all allegations of abuse should immediately be investigated. She stated the facility policy regarding abuse is current and should be followed. The facility neglected to thoroughly investigate allegations of sexual abuse to client #2 by former client #4 once management staff were made aware of these allegations. The facility also did not thoroughly investigate the possibility former client #4 had disabled the bedroom door alarms. Direct care staff also failed to report to management incidences of former client #4 entering the bedroom areas of clients #1 and #2. The failure of management staff to detect, identify, investigate these allegations resulted in	W 149	For citataions W149, please refer to pages 5.	

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W 149	Continued From page 9 their facility policies for reporting and investigating abuse not being consistently implemented. These failures resulted in the facility's systemic failure to provide statutorily mandated services of client protections to the clients residing in the facility.	W 149	For citataions W149, please refer to page 5.	
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to conduct a thorough investigation of allegations of client to client abuse involving clients (#1, #2) by former client #4. The finding is: Management failed to thoroughly investigate allegations of client to client sexual abuse. Review on 4/6/18 of client #2's record revealed an individual program plan (IPP) dated 5/18/17. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disabilities and Schizophrenia (Undifferentiated type). The IPP indicated client #2 had been adjudicated incompetent and had a guardian of the person appointed to act on his behalf. Additional review of his IPP revealed "Will have a privacy goal implemented as needed. He has no issues with maintaining his privacy or the privacy of others at this time." Review on 4/6/18 of former client #4's record revealed an IPP dated 1/30/18. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disability,	W 154	This standard will be corrected by the following actions: A. All clinical and managerial staff will be provided investigative training. Training will include, but will not be limited to, proper reporting procedures, investigative requirements (i.e. HCPR reporting, guardian notifications, etc), timeframes, etc. B. Qualified Professional will provide training to all consumers regarding their individual rights, various types of abuse/ neglect, and who to report to. C. Qualified Professional will provide education to all consumers regarding privacy. D. Qualified Professional will provide training to all staff regarding the purpose and proper implementation documentation of bed checks. E. Residential Manager and Qualified Professional will monitor and document adherence all corrective measures daily for a month. Afterwards, they will each provide on-going monintoring 3x/weekly. F. Program Manager will monitor and document adherence to all corrective measures weekly for a month. Afterwards, Program Manager will provide on-going monitoring bi-weekly.	5/24/18

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	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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W 154	Continued From page 10 Attention Deficit Hyperactivity Disorder, Impulse Control Disorder, Episodic Mood Disorder, Pervasive Developmental Disorder. Further review of this IPP revealed a behavior support plan dated 3/19/18 to address target behaviors of Physical Aggression and Property Destruction. Review on 4/9/18 of a note by staff revealed former client #4 was physically aggressive towards staff and exhibited suicidal ideations on 3/27/18. Direct Care staff contacted the Police Department and former client #4 was hospitalized on 3/27/18. Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed former client #4 was hospitalized and probably would not be re admitted to the facility when he is discharged. Alternative placement is being pursued by the hospital. Review on 4/9/18 of an investigation dated 2/10/18 revealed a direct care staff reported to management staff that client #2 reported to him that former client #4 inappropriately touched clients #2 and #1 in the genital area. Statements were taken from several staff in the facility and clients #1, #2 and #4 were interviewed. After reviewing the statements the investigative team determined these allegations were unsubstantiated as client #4 was hospitalized during the time frame client #2 alleged that these events took place. Interview on 4/6/18 with the Residential Manager via phone indicated after this investigation dated 2/10/18 she instructed direct care staff to be aware of client #4's location every 15 minutes when he was in the home. She also instructed	W 154	Please refer to page 10.	

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W 154	Continued From page 11 staff to be certain the door alarms above former client #2 and client #4's bedroom doors were operational. She explained that she told direct care staff to report any interaction between clients that was inappropriate. She stated during the last week in March 2018 (uncertain of specific date) a direct care staff reported to her client #2 told him former client #4 had inappropriately touched him. She stated former client #4 had been hospitalized on 3/27/18 and the time frame client #2 provided to direct care staff did not seem possible, so she chose not to investigate these allegations. Interview on 4/6/18 at the vocational center with client #2 revealed former client #4 had inappropriately touched him in the genital area with his mouth about two weeks ago. He stated former client #4 came into his bedroom at night, shut the door, pulled down his pants and kissed his genital area with his mouth. He stated former client #4 then left his bedroom, shutting the door behind him. When asked if this was witnessed by his roommate (who is not interviewable) or by the 2 direct care staff working in the facility, he stated, "No." It should be noted client #2 was crying during this interview and afterwards he vomited into a trash can in the room where he was being interviewed. This interview was also witnessed by the vocational staff who works with him as a Qualified Professional (QP). Additional interviews on 4/6/18 with client #5 and #6 revealed no inappropriate touching by other clients or staff. Clients #1 and #3 were not interviewable. Interview on 4/6/18 with former client #4 at the hospital revealed he had no knowledge of any clients entering other clients bedrooms without	W 154	Please refer to page 10.	

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W 154	Continued From page 12 their consent. He stated he had never entered clients #1 and #2's bedrooms. He stated client #2 had come to his bedroom after he invited him to come and play a video game with him. He stated client #2 sat on his bed and watched him play a video game. He denied ever touching any of the clients in the facility. He asked this surveyor, "Who would tell you I went into their bedrooms?" This interview was witnessed by former client #4's therapist at the hospital. Interview on 4/6/18 with staff #A revealed he had witnessed former client #4 going into client #2's bedroom and on one occasion, he had shut the bedroom door. He did not report this inappropriate interaction to management staff. Interview on 4/6/18 with staff #B revealed he had seen former client #4 go into client #1's bedroom and touch his face and ears. He stated this was not reported to management staff. He also stated when he was working in March, he was in the hallway bathroom assisting client #1 with undressing when former client #4 walked into the bathroom. He stated when former client #4 realized staff #B was in the bathroom with client #1, former client #4 quickly exited the hallway bathroom. Staff #B did not report this to management. Additional interview on 4/9/18 with the Residential Manager revealed she was not told by direct care staff of former client #4 entering the bedroom areas of client #1 and client #2. She stated sometime during the month of March 2018 she noted when she came into her shift in the facility that the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. She stated she did not report this	W 154	Please refer to page 10.	

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W 154	Continued From page 13 but instructed direct care staff to be aware of these alarms while they were working in the facility. Review on 4/9/18 of the facility policy regarding Abuse and Neglect page C.4.5 revealed "Any incidents of abuse or neglect are to be reported and investigated immediately, and according to prescribed procedures." Sexual Abuse is defined as "Any physical or provocative advances, such as caressing, fondling, sexual contact , sexual intercourse, etc. Encouraging a person to participate in nonconsensual sexual activity. Encouraging or allowing a person to be in any form of undress or to participate in sexual activity for the gratification of staff or other persons." Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of allegations involving former client #4 and client #2 that were given to the Residential Manager in March 2018. He stated he was also unaware of allegations of former client #4 entering the bedroom areas of clients #1, #2. He was also unaware the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. Additional interview revealed the facility policy regarding Abuse and neglect is current and should be implemented. Interview on 4/9/18 with the Operations Manager revealed all allegations of abuse should immediately be investigated. She stated the facility policy regarding abuse is current and should be followed. The facility failed to thoroughly investigate allegations of sexual abuse to client #2 by former client #4 once management staff were made	W 154	Please refer to page 10.	

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W 154	Continued From page 14 aware of these allegations. The facility also failed to investigate the possibility former client #4 had disabled the bedroom door alarms and failed to ensure direct care staff reported to management former client #4 entering the bedroom areas of clients #1 and #2. The failure of management staff at the facility to detect, identify, investigate these allegations and follow their own facility policy reporting and investigating abuse resulted in their systemic failure to ensure statutorily mandated services of client protections to the clients residing in the facility.	W 154	Please refer to page 10.	