STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411083	A. BUILDING: _____ B. WING _____	05/21/2020

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BLESSED ALMS II LLC	3909 BEARS CREEK ROAD GREENSBORO, NC 27406

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V 000	INITIAL COMMENTS A complaint survey was completed on 5/21/20. The complaint was substantiated (intake #NC00165118). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000	DHSR-Mental Health JUN 24 2020 Lic. & Cert. Section	
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to	V 115	The statements regarding seconds here are not true. They are taken out of context, literally. This is due to the fact that the clients received larger than portion sizes the first serving, including double meat. They never received regular portions recommended for by nutritionist. We, in the past were advise during doctor visits with the clients that we must take care in the way we were feeding clients that we take into consideration that clients are showing up with high cholesterol, pre-diabetes, and obesity. We addressed this by speaking with our state consultant regarding whether we are required to provide snacks. We were advised of the rule: We were to serve or prepare meals for clients that were nutritious. There were no requirements that we provide snacks. We decided to cut out snacks with high sugar content and fat content (sweet pastries, cakes, candy, Kool-aid, Sodas, etc.) This was to address clients coming in with high cholesterol, in pre-diabetic state and with high blood pressure. We substituted these with all kinds of fruit and apple/orange juice and a high intake of water. Clients left our home in a healthier state that they came in with. Clients were served three nutritious meals a day when they were out of school, breakfast and dinner when they were in school. Clients were served breakfast in the group home, and then served breakfast again when they arrive at school. Clients were not only served additional breakfast at school, they were also allowed to take	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bobby Cuffee TITLE DIRECTOR (X6) DATE 6/18/2020

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V 115	Continued From page 1 assist in supervision of the children. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to serve or prepare meals for clients that were nutritious. The findings are: Interview on 3/25/20 with FC #2 revealed: - She was not provided enough food when she lived in the group home. - Clients were never allowed to have snacks. - She lost weight when she lived at the group home. - She weighed 140 pounds when she was admitted and weighed 127 when she was discharged. Interview on 3/31/20 with FC #3 revealed: - She was not full when she ate meals at the group home. - At times, clients were not allowed to have seconds at meal time. - "I used to sneak apple juice but they never found out. We all snuck food from in the garage, the juice and chips in the garage. We did this because we were all hungry." Interview on 4/2/20 with FC #4 revealed: - She was not provided enough food when she was living in the group home. - Only one staff allowed the clients to have seconds at meal time. - She and the other clients were not allowed to	V 115	additional biscuits, juices, and snacks from carts at school to eat during the day or take home with them. The rule was we had nothing to do with any food they received at school. They just had to eat it before returning to the group home. This is all to say that clients ate all the time, the nutritious meals in the group home and at school. FC#2 never complained about not getting enough food during her stay in the group home. There is no documentation of her ever weighing 140 pounds. When she arrive she stated "I have to maintain my six pack". She fancied herself as a man. This was her alternative sex preference. She made it clear she preferred girls. She tried to carry herself as a man. Her weight may have fluctuated up or down just a little the entire time she was here. (phone interview with Dr. Jason Jones reveals her initial visit she weighed 134 pounds; her last visit she weighed 132 pounds).The investigation made no mention of contacting the primary care provider (Palladium Primary Care or Dr. Jason Jones who took her vitals each time she saw him). The investigation didn't verify FC #2 statement of loss of weight. FC #2 never complained to her primary care doctor or her medication management doctor about weight loss; and neither of these medical care provider expressed any concern regarding weight loss for this client. See doctors report attached. FC #3 was already extremely overweight upon her arrival. This was her second admission with us. She weighed 123 pounds at her first admission. She weighed right at or over 200 pounds at her second admission. She had gained so much weight she was almost unrecognizable. Even tough she was in this state we fed her the same as everyone else. Her weight caused her problems walking, catching her breath, and she sweated so bad, the chair would be wet when she got up from sitting. Her weight was a health concern for us, but because we never receive a request to feed her less, we didn't. She was always wanting to eat, even after having two portions at meal time. We are not supersized she stole food from the surplus food. FC #3 was also seen at her primary care physician (Palladium Primary Care and for medication management at Monarch). Her vitals were taken at each visit. Her weight had an effect on her health. She indicated she had hurt her ankle at her last placement. Her weight caused her problems with that ankle.	

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V 115	Continued From page 2 have snacks. - She lost 40 pounds while she lived at the group home due to the lack of food. - "We never got snacks. If I brought something from my school lunch or if my mom sent back food, they (the staff) would not let me eat it." Interview on 4/17/20 with former staff (FS) #7 revealed: - Clients were not fed enough food. - Clients who had brought snacks from home, could eat a snack. - "There were times we were told they could eat seconds and then other times we were told they could not get seconds. It was up and down (the rules about getting seconds) and it was so confusing. [The APL #2] was usually the one who told us to not give seconds." - " ...Every girl I saw come in lost weight. I was not concerned they lost too much weight because many were overweight. I was concerned I think they needed more food. I think they needed a snack after dinner especially due to the amount of medicine they took." Interview on 4/21/20 with staff #4 revealed: - When clients asked for seconds, they are not allowed to have seconds at meal time. - She worked in the mornings but has heard clients no longer receive snacks. - "No, she (the APL #2) doesn't allow extra food (seconds)." Interview on 4/22/20 with the QPL revealed: - Clients were provided "seconds and thirds" at meal time. - Clients were provided fruit for snack. - The clients who lost weight did so because they wanted to lose weight.	V 115	FC #4 never complained about food here. She had issues with her back due to her extremely large breast, and she was overweight. There is no way she lost 40 pounds here and there were no concerns from her primary physician and her medication management doctor, her parent or social worker. She was also referred to a plastic surgeon after an extensive examination regarding her back issues and the need/desire for a breast reduction. She was advised by the doctor that she would have to lose some weight to have the surgery. A 40 pound weight loss would have been addressed by the doctor. This is simply not true. Again the investigation did not verify this statement by FC #4 with an interview with a physician. Note: These clients all had issues with the fact that they could not eat candy, cakes, and all manor of sweets and sodas in the group home. However, the fact that we do not provide sweet snacks or soda are discussed with the legal guardians and parents at the time of admission. They were advised that clients were not to bring these item back to the group home from home visits, however when they did those items were made available at meal times. They are given the opportunity to refuse admission if they don't agree with the procedure regarding snacks. We never received communication of any concern regarding food or lack of food from any parent or legal guardian of any child in this report. Again, the advisement from the school that clients are fed a full breakfast upon arrival at school and given additional biscuits (sausage, ham, chicken), juices, and snacks to eat or take home is why they were not over fed in the mornings. This is why the morning staff may have said they do not get seconds in the morning. FS #7 is a former staff for a reason. There is no reason to expect positive comments from former staff. That is all we will say about that. Note: This decision regarding snacks was made in the best interest of the client's health; after sessions with the physician. However at one point we did by some snacks as periodic rewards for client's who demonstrated consistent improvement in behavior and work towards their PCP goals. This was stopped when client's stole them.	

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V 115	Continued From page 3 Interview on 4/22/20 with the APL #2 revealed: - Clients are provided seconds at meal time. - Clients are not provided snacks. - Client A5 lost weight and did so because she wanted to lose weight. Client A5 purged her food. - "I cut out snacks years ago because I was told by a state representative that we do not have to give them snacks. The clients were stealing food and would eat the whole box of snacks and I stopped buying snacks."	V 115	To address client A5; we have to say that she was extremely self conscience about her weight. She felt she was fat and let everyone know it. We actually had to process with her to get her to eat. Once the doctor said she was obese, she began to put her finger in her throat and throw up her food. It was her peer that told us this was happening. She became angry that we asked her to stop, that we would serve her smaller portions. She agreed and this behavior was stopped by her. See doctors report for each of these clients attached for proof of client making untruthful statements. See vitals from doctor attached. Plan of Correction: (V115): This addresses the deficiency sited here. We will continue to adhere to the rule. If additions to the meal or substitute is provided, the client will be required to sign a meal log to that fact. The newly hired program manager will monitor meal logs to assure this plan of correction is followed.	
V 298	27G .1706 Residential Tx. Child/Adol - Operations 10A NCAC 27G .1706 OPERATIONS (a) Each facility shall serve no more than a total of 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's educational needs are met as identified in the child's education plan and the treatment plan. Most of the children will be able to attend school; for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment	V 298	We admit that we did not adhere to the letter of the rule, however our facility was open 24/7/365. We did use our sister facility to assist in different situations and circumstances. As it relates to FC #4; She was admitted to BA II. This report indicates that she was moved to our sister facility on 11/20/19. This is an error, as she was taken to our sister facility on 11/23/19. She was supposed to be picked up by her mother for a Thanksgiving visit, however her mother called and indicated she could not make it all the way to Greensboro, and asked if we could meet her half way in Salisbury, NC. We did transport her and this can be verified as a driver hit staff in the rear while they were transporting FC #4, and the mother had to wait. She had an extended visit and returned to start attending a day treatment school. She was showing consistent improvement, but was in and around constant ciaos by the other clients at BA II, so we placed her at our sister facility until we could get the situation with the other clients at BA II calmed down. She attended school for a couple of weeks and continued her improvement. She then went home for a Christmas visit. She stayed through new years. The mother decided she had done so well, she kept her at home. This was a successful transition from the group home back to the family home.	

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V 298	Continued From page 4 plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to operate 24 hours a day, 7 days a week, each day of the year effecting 1 of 1 current client (#1), and 3 of 3 former clients (FC) (FC #2, FC #3, and FC #4). The findings are: Interview on 4/1/20 with client #1 revealed: - She was admitted to Blessed Alms II LLC but slept over at the sister facility A "a lot of times." - The clients from Blessed Alms II LLC would sleep over at the sister facility A when only 2 clients were in Blessed Alms II LLC. Interview on 3/27/20 with client #1's legal guardian revealed: - Her daughter was admitted to Blessed Alms II LLC but had slept over at the sister facility A. - "I never know when she will be over at the other group home (sister facility A)." Review on 5/7/20 of client #1's record revealed: - She had been admitted to Blessed Alms II LLC. - There was no admission assessment for the sister facility A. Interview on 4/16/20 with FC #2 revealed: - She was first admitted to the sister facility A. - In December 2019, she was moved to Blessed Alms II LLC. - In January 2020, she was moved back to the	V 298	As it relates to FC #3; She was originally taken to our sister facility because she needed time to calm down from trying to fight a peer she said stole her ear rings from her room. It was a bad situation and she was out of control. However she was also at our sister facility during the day because the school system could not get her placed in the appropriate school setting. While all the other kids were in school we operated out of our sister facility because that is where our office was located. The middle school would not admit her and she was referred to a Day Treatment school. They would not admit her because her IQ score was to low. She was then referred to an alternative school. They indicated they had to research her situation before they could admit her. She was not admitted. Staff attempted to initiate some education processes with her, but she refused to do the assignments. This was done at the sister facility. Her behavior escalated daily, and along with her refusal to engage in treatment, she was eventually sent to a PRTF. As it relates to client #1. We used our sister facility multiple times in her case. Before she made the change to consistent corporation, she was involved in several episodes of extreme verbal and physical aggression towards staff and peers. She needed time away to pull herself together. The legal guardian revealed to us that she told the state person that she had no concerns with our agency, and she has kept her daughter here despite the report from the state worker. The work we have done with client #1 has benefited her and she is currently doing very well in care. As it relates to FC #2; she was never admitted to our sister facility, she was just checked in there. She was taken to BA II after she was checked in. Our sister facility was used in her case because she would not comply with anything. She would not work on her goals, she would not abide by any rules, and her points progress in the negative consistently. We hoped a change of environment would motivate her to go towards the positive. However she found herself involved in inappropriate sexual behavior and we sent back to BA II. On 1/9/20 she destroyed her room because she said a peer stole her clothes and sold them at school. We used our sister facility instead of charging her for destruction of property.	

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V 298	Continued From page 5 sister facility A because she was the only client at Blessed Alms II LLC. Interview on 3/25/20 with FC #2's legal guardian revealed: - FC #2 was admitted to the sister facility A. - Then FC #2 was moved to Blessed Alms II LLC (date unknown). - A week after she was moved to Blessed Alms II LLC she was moved back to the sister facility A. Review on 5/7/20 of FC #2's record revealed: - She had been admitted to Blessed Alms II LLC. - There was no admission assessment for the sister facility A. - Review of FC #2's Admission Assessment: It was noted that she was admitted to Blessed Alms II LLC but an "incident occurred while at [sister facility A] on 2/3/2020." Review on 3/27/20 of Incident Response Improvement System (IRIS) revealed: - Date of Incident: 2/3/20 - "The consumer started her non-compliance on Sunday night when she came back from a home visit to get clothes. She came in angry and first refused to comply with the procedure to inventory any new items brought into the group home. She became even more angry when told she had to bring the new items from her room to be inventoried. The group home did not know why she was angry, but we suspected that she just did not want to come back to the group home. She had acted like this before after a visit. She however did not calm down, and became verbally aggressive using extreme profanity and refused to comply or engage in treatment at all. bedtime was at 8:00, she refused to go to bed and set in the common room until 10:00 before we were finally able to get her to go to bed. This behavior	V 298	Management replaced the stolen clothes and she was able to return to BA II. However, she still refused to engage in treatment, so we told the guardian she need new clothes because she only had a few pants to wear and they were all cut up. This is when she went with the guardian home to get new clothes. The other clients from BA II were at our sister facility because it was Sunday and they attended church, participated in a activity after church, returned to our sister facility where they along with all the clients, watched movies on this day. FC #2 was supposed to be back, but the guardian got her back very late. She was supposed to meet the other clients here and return to BA II with them. She got her back so late the staff had taken the clients back to BA II. FC #2 came in extremely angry. She refused to comply with any staff directives. She was so out of control and use such extreme profanity, we called the guardian to come back and get her, she refused. She did not even come in when she brought FC #2 back. She stomped up and down the halls trying to wake up the other clients. She used language like: "Suck my Dick"; "Motherfuckers"; "Bitches" She finally went to bed after about 3 hours of doing what she wanted to do. Staff never touched her. She was awaken first by staff the next morning so she could shower and complete her morning routine first. She refused to get out of bed and refused to complete her morning routine. She instead waited on administration to arrive. She used the same language as she used the night before. She ran through the house, she burst into the office and tried to take the phone. We called her guardian and put the phone on speaker. We would not put the phone in her hands for fear of her destroying it. She chased the on-duty staff through the house as she tried to let the guardian know what was happening. She made accusation, but there is video available to prove her accusations are a lie. She made her threat that she was going to get the group home shut down. She said she was going to be wearing the owner's jewelry. he said she was going to be driving the owner's car. She said the owner will not be living in a nice house. The police had to be called.	

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V 298	Continued From page 6 carried over into the next morning. She refused to get out of bed as she was the first to be prompted. She refused to get up and eat or take her medication. The rule is that all consumers have their morning routine completed, be dressed and sitting in the common room by 7:00. This consumer was at this location because she got back late and a decision was made to allow her to spend the night. Interview on 3/31/20 with FC #3 revealed: - She was admitted to Blessed New Alms II LLC but slept over at sister facility A. - She slept over at sister facility A when the rest of the clients at Blessed Alms II LLC were away on overnights. Review on 5/7/20 of FC #3's record revealed: - She was only admitted to Blessed Alms II LLC. - There was no admission assessment for the sister facility A. Interview on 4/2/20 with FC #4 revealed: - She lived in both group homes. - She first lived in Blessed Alms II LLC and was then moved to the sister facility A on 11/20/19. Review on 5/7/20 of FC #4's record revealed: - She was only admitted to Blessed Alms II LLC. - There was no admission assessment for the sister facility A. Interview on 4/22/20 with the Qualified Professional #1/Licensee (QPL) revealed: - Clients were moved from one group home to the other group home he owns. - "When we have no electricity or during the holidays and the kids are left we have gotten them together with the other kids (at the other group home). We talk to the guardians or parents	V 298	Plan of Correction: As a result of this action there is going to be an agency policy change. Blessed Alms II will never use her sister facility to assist in any situation of extreme physical aggression or property destruction, as a place to calm a client down. The new policy is that when extreme physical aggression and/or property destruction is done by a client; they will now be discharged from care At Blessed Alms II. The parent, social worker, or guardian will have to remove the client from the facility within 72 hours. The agency clinical person will assist with documentation and locating the next placement. If there is a lone client left in the home during a holiday, that client will be left alone in the facility with staff, and not be joined with other clients who had no visiting resource for the holiday. Blessed Alms II LLC will assure that any resident admitted to the Blessed Alms II Group home will remain at Blessed Alms; and never spend the night at her sister facility. If there is in-climate weather and electric services are lost, or any other unforeseen disaster, approval from parent, legal guardian and care coordinator will have to be given to house client at an alternate location. The new program manager/clinical person/and director will monitor all admissions; behaviors; and changing circumstance monthly, to assure this plan of correction is followed	

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V 298	Continued From page 7 about this."	V 298		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice	V 364	The facility failed to ensure privacy during telephone calls; failed to allow communicate and consult with parents or guardians; and made clients attend worship services The above is not is statement of fact. The rule says the facility will allow clients to Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; The rule does not say allow client to make private phone calls. G.S. 122-51 through G.S. 122-61 says each (adult) client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Make and receive (confidential telephone calls). All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; It appears the state worker combined the adult rule with the minor rule. At admission the rule regarding telephone calls to parents and guardians are discussed. Every parent and guardian is asked to provide contact information to the group home so that the client can contact them. Parents and guardians are also made aware of the phone schedule when a client is not on level and when they make level. Every parent and guardian is made aware that clients can call and a place is made available for them to talk. However there will be periodic monitoring to assure clients are still talking to the parent or guardian, and have not hung up and called some other person who the parent or guardian may not want them talking to; or planning to get a ride after going AWOL from the group home. That is the monitoring that is done. Every parent and guardian is aware and has the option to refuse admission if they have a problem with this. We have never had a parent or guardian that did not agree with this. We do not sit and listen to every word of a client's call. We just make sure	

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V 364	Continued From page 8 upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to	V 364	a client is not putting herself at Risk. Clients are allowed to contact parents and guardians during appropriate hours, and when they are in crisis and the parent or guardian can be reached. After hours, late hours and weekends are difficult time to make contact with parents and guardians. This is difficult to get clients to understand. However the effort is made. Clients, parents and guardians are made aware of the level system upon admission. It is explained that the level system is a behavior management system that rewards good behavior and consequences inappropriate behaviors. This applies to phone calls also. When a client is progressing up the level system they are rewarded with increasing time for their calls. when they are regression in a negative on the system, their calls are limited to three time a week until they get back in the positive. This system has been used in the facility for almost 17 years now. Every parent and guardian has the right to refuse admission if they have an issue with the point/ level system. They all agree that this structure is needed to build character in their child and we have never had one parent or guardian that did not agree with it or refuse admission because of it. It is not right that state worker use an establish system that works for those clients that are making the effort to change their lives, against us after 17 years of use in our operation. No client has ever been forced to attend religious worship here. We have had clients who did not want to go into church services. However very parent or cardigan is made aware of the fact that we are a christian organization when their client or child is brought to the group home for admission. The fact that we attend church is made clear to them. We have never had a parent or guardian tell they did not want their child to attend church. However we have a democratic process for the clients when it comes to going to church. They meaning the clients take a vote. The majority wins. When a client is adamant about not attending church, we try to get off duty staff to come in so that client can stay at the group home. However this is not possible all the time. So sometimes a client will travel with the other to church, but does not have to go into the actual church service. Our church has quiet rooms	

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V 364	Continued From page 9 proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;	V 364	where the client can sit and not have to go into the actual church services. There are times when we do have everyone stay at the facility and some watch a church service on television. However this creates issues among the clients. We have even had a client who said she was an atheist and did not want to go to church. However her peers talked with her and she did attend. This was mostly because she wanted to hear the director sing who was a lead on the church choir. She however did start to go to church, and to everyones supersize, she walked up front one Sunday and dedicated her life to Christ. She is actually on the church records for her dedication. However, every parent or guardian who has brought a client here has wanted their child to attend church. Not one has taken the option to refuse admission because their child would be attending church. Plan of Correction: Blessed Alms II will continue to adhere to the rule which says each minor receiving service will be allowed to: Participate in religious worship. Blessed Alms II will assure that if a client does not want to attend religious worship with the group home they will have options not attend services. 1. They will have access to a quiet room at the church to wait for the others attending services. 2. They will be allowed to remain in the group home if additional staff is available to meet the state requirement for 2 staff for I, 2, 3 or 4 clients, or stay in their room while peers who want to view religious worship services on television. The new Program Manager and LCMHC-S will monitor this corrective action (related to additional rights in a 24-hour facility), weekly to assure this plan of correction is followed.	

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V 364	Continued From page 10 (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed.	V 364		

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V 364	Continued From page 11 Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to ensure privacy during telephone calls; failed to allow communicate and consult with parents or guardians; and made clients attend worship services affecting 1 of 1 current client (client #1) and 3 of 3 former clients (FC) (FC #2, FC #3, and FC #4). The findings are: Review on 3/31/20 of client #1 record revealed: - Admission Date: 1/24/20 - Diagnoses: Attention Deficit Hyperactivity Disorder; and Disruptive Mood Dysregulation Disorder - Age: 15 years-old - Review of client #1's Person-Centered Profile	V 364		

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V 364	Continued From page 12 (PCP) updated 1/13/20 revealed: " ...has a history of hospitalizations and a previous group home placement. She also has a history of suicidal ideation and harming herself." -No documentation of the need to limit phone calls or that phone calls needed to be monitored. Review on 5/7/20 of FC #2's record revealed: - Admission Date: 11/13/19 - Discharge Date: 2/5/20 - Diagnoses: Major Depressive Disorder; Adjustment Disorder; and Post-Traumatic Stress Disorder - Age: 16 years-old - Review of FC #2's Person-Centered Profile (PCP) updated 1/28/20 revealed: " ...has a long history of receiving services including Outpatient therapy and intensive In-Home services. Client is also involved in DJJ (Department of Juvenile Justice). Client's behaviors have been increasing, which include running away, making threats, highly risky/sexual behavior, fighting, stealing and truancy issues." -No documentation of the need to limit phone calls or that phone calls needed to be monitored. Review on 3/31/20 of FC #3's record revealed: - Admission Date: 10/28/19 - Discharge Date: 1/8/20 - Diagnoses: Unspecified impulse control Disorder; Disruptive Mood Dysregulation Disorder - Age: 15 years-old - Review of FC #3's Person-Centered Profile (PCP) updated 12/12/19 revealed: "She has refused to participate in treatment, refused to engage in therapy, demonstrated complete non-compliance, with open defiance and opposition. She has demonstrated verbal and physical aggression, with some threatening behaviors."	V 364		

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V 364	Continued From page 13 - Medical/Dental Concerns: "None reported." -No documentation of the need to limit phone calls or that phone calls needed to be monitored. Review on 4/2/20 of FC #4's record revealed: - Admission Date: 11/1/19 - Discharge Date: 1/8/20 - Diagnoses: Major Depressive Disorder; Attention Deficit Hyperactivity Disorder; Post-Traumatic Stress Disorder; and Sexual Abuse of a Child (Victim) - Age: 14 years-old -No documentation of the need to limit phone calls or that phone calls needed to be monitored. Finding #1: Interview on 4/2/20 with client #1 revealed: - Phone calls can be made on Monday, Wednesday and Fridays. - Her phone calls are limited to 5 minutes. - She was not allowed to make private phone calls. - She was not allowed to talk to her legal guardian privately. Interview 3/31/20 and 4/16/20 with FC #3 revealed: - When she lived in the group home, her phone calls were monitored and limited to 5 minutes. She could not make telephone calls on the weekends. - "I am in a higher level (Psychiatric Residential Treatment Facility) and they (staff) give us more time here (to make calls) than they did there." Interview on 4/2/20 with FC #4 revealed: - When she lived in the group home, phone calls had to be made in the kitchen or den. - She could not make a telephone call in her bedroom.	V 364		

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V 364	Continued From page 14 - She was allowed to make a 5-minute telephone call, two times during the week. Interview on 4/22/20 with the Qualified Professional #1/Licensee (QPL) revealed: - Telephone calls are monitored by staff. - The clients do not have treatment goals/strategies that indicate phone calls should be monitored. - New clients can make 5-minute phone calls on Monday, Wednesday and Friday. - Clients who have been on level 1 can make 10-minute calls Monday-Friday. - Clients who have increased in the level system get an additional 5 minutes for each level. - He created the telephone call system and level system. Finding #2 Interview on 4/16/20 with FC #2 revealed: - The clients were made to attend church. - "If [the APL #2] said we were going to go to church, we were going to go." Interview on 4/2/20 with FC #4 revealed: - She was made to attend church. - "They (the Associate Professional/Licensee #2 (APL #2) and the QPL) got mad because I said I was atheist and forced me to go to church." Interview on 4/17/20 with former staff (FS) #7 revealed: - The clients attended church. There was one client who did not want to go to church but she had to attend. - "The rules changed (about going to church) depending on how many staff were available." Interview on 4/22/20 with the APL #2 revealed:	V 364		

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V 364	Continued From page 15 - Clients were not made to attend church. - "They (the clients) chose to go to church they asked us, 'when are we going to church?' because we take them out to eat. If they don't want to go to church, they have the option to sit in the van or the foyer of the church." Interview on 4/22/20 with the QPL revealed: - Clients attended the same church he and the APL #2 attended. - Clients were not forced to attend church. - "Most (clients) want to go and for those who don't want to go church we have a staff stay here (at the group home) with them. We have them sit in the foyer at church or we have a section in the back of the church. We always take them out to eat afterwards so they want to go."	V 364		
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	V 367	The facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. As it relates to FC #3; the client arrived at our facility with a foot issue. She indicated she had fallen in the shower at her previous placement. She had brought with her an ankle brace, which she would not put on. This was her second time at our facility. When she left our facility to go to a PRTF she weighed 123 pounds. When she returned for her second admission she weighed 227 pounds. Her increased weight of 104 pounds contributed to her ankle issues. When she got up from bed in the mornings, she complained about pain in her ankle. She had trouble walking some days, and her ankle would give out on her at times. she was taken to the doctor on 11/14/19 because it was a follow up from her 10/31/19 visit and she indicated she was still having pain in her ankle from her fall in the shower at her last placement. She was taken to the doctor again on 11/21/19 and reported to the doctor what she had told staff at the group home. She had accidentally fell at the home and scraped	

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V 367	Continued From page 16 identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (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).	V 367	her leg. She told staff her ankle gave out on her walking up the steps at the group home. we took her to the doctor because we were concerned that her weight was causing her issues with her ankle. We thought we were acting in the best interest of the child. We did not think an incident report had to be written because she slipped on the step. She was taken to the doctor again on 12/20/19 for follow up. At that time FC #3 made no mention of her ankle or any other pain. She was seen for her follow up and a boil under her left armpit. She was discharged on 01/08/20. As it relates to FC #2; the design she put on her arm was done by a led pencil. However it was over a week before we had any knowledge of the design on her arm. She was being seen by the LCMHC-S when he got a glimpse of something on her arm. She was still trying to hide it. He called staff and made FC #2 show him what was on her arm. She indicated she had done it at school. She said she got it from some rapper video she saw at school. She had hid it so long it was healed by the time the group home found out about it. Staff did put an antiseptic on it where she had been bothering it. a picture of it was texted to the guardian, and the guardian was supposed to speak to staff after she spoke with FC #2. The guarding cursed out FC #2 and told her this was devil worship. FC #2 was asked if she wanted to go to the doctor, and she refused. The guardian never asked anyone to take FC #2 to the doctor. The school was advised as they should have completed an incident report since she did this to herself at school. We did not do an incident report as she was not taken to a doctor, she never complained of pain, and did not want to go to a doctor, and the guardian did not even mention taking her to a doctor. Therefore we did not think an incident report was needed. As it relates to client #1; This situation was just so unnecessary. She was just having an unprovoked episode of verbal aggression that was being processed through by on duty staff. She had walked out of the facility, but not off the property. On duty staff ha went outside and processed with her. Staff was just trying to get her to come and sit in the common room and calm down. She refused to be compliant and was standing next to the door.	

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V 367	Continued From page 17 (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Finding #1 Interview on 4/22/20 with the QPL revealed: - He did not know for sure how FC #3 hurt her foot in December 2019.	V 367	every attempt was made to de-escalate this situation. The door was never slammed against her foot when she stuck it in the door. This was just her messing with Mr. Bobby, as she later told staff. However, we are 2 minutes away from a substation for the community police. We have been here so many years, we have a great working relationship with the police at the substation. I just called to have an officer come an speak with client #1. We have had many instances where we have spoken with the officers and they have suggested that we just call for them to come before situations escalate into a crisis. This was our effort to use a resource we had. There was no intent to ever hurt client #1. We even got her mother on the phone during this situation. She was made aware of all that was going on. She was upset at her daughter's behavior and did let her know this. However she would not have a personal conversation with her daughter. As the officer just talked with client #1, we did not feel a level II incident report was warranted. Plan of Correction: A decision has been made by administration that a level I incident report will be completed for every instance of verbal aggression, and non-compliance by any client. A decision has been made to have contact with Ms. Debbie Powell the incident report specialist at Sandhills Center to assess incidents to determine the need for a level II incident report. These measures with correct the deficient area concerning when a incident report should be written A decision has been made that the new Program Manager will be officially trained in incident report writing to take over writing incident reports and the QPL will remove himself from writing incident reports. This measure will prevent the QPL, who has been deciding if an incident report would be written, and had caused the deficiency, from the decision process. This measure to place a new incident report writer in place, will prevent the problem from occurring again A decision has been made to have the LCMHC-S monitor the incident report log monthly to ensure it will not occur again	

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	MHL0411083	A. BUILDING: _____ B. WING _____	05/21/2020

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V 367	Continued From page 18 - Denied he pushed FC #3 - "[FC #3] was running up and down the hill at [sister facility] ...[FC #3] hurt her foot at [prior placement]. [FC #3] said she slipped on the stairs at [the sister facility]." - "We didn't do an incident report. [FC #3] said she slipped on the steps that was all." Finding #2 Interview on 4/22/20 with the QPL revealed: - He did not know when FC #2 cut the word "Die" and other symbols on her arm. - FC #2 engraved the word "Die" and other symbols on her arm while at school. - Peroxide was put on the wound by staff #3 "because [FC #2] was picking at it." - FC #2 had not seen by a medical provider for the wound. - "It was discovered. It had healed over. She never complained about no pain." - An incident report was not completed. Finding #3 Interview on 4/22/20 with the QPL revealed: - Sometime in March 2020, client #1 stood next to the front door. - He told client #1 that "we could not stand here and let all the heat out." - He closed the door 3 or 4 times when client #1 "stuck her foot in the door." - He called the police. - "Every time I tried to close the door [client #1] would stick her foot in the door. She stuck her foot in the door because she was mad about something. I was just trying to close the door. She had on crocks. " - "She never complained about her foot being hurt."	V 367		

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V 367	Continued From page 19 - The police were called. - An incident report was not completed.	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. This Rule is not met as evidenced by: Based on record reviews and interviews, 3 of 7 staff (the Qualified Professional #1/Licensee (QPL), Associate Professional/Licensee #2 (APL #2) and staff #3) abused 1 of 1 current client (#1), 3 of 3 former clients (FC) (FC #2, FC #3, and FC #4) and 1 of 7 staff (the QPL) neglected 1 of 3	V 512	3 of 7 staff (the Qualified Professional #1/Licensee (QPL), Associate Professional/Licensee #2 (APL #2) and staff #3) abused 1 of 1 current client (#1), 3 of 3 former clients (FC) (FC #2, FC #3, and FC #4) and 1 of 7 staff (the QPL) neglected 1 of 3 former clients (FC #2). As it relates to FC #3; This report is filled with incorrect information. First APL #2 was not even at the facility the day this situation occurred. QPL was not actually working a shift. He was in his office completing some documentation. Staff #2 and #3 were the on duty staff and handling the situation with FC #3. The situation was that the staff #2 and #3 were conducting a movie in the common room for the consumers. FC #3 was asleep and snoring loudly. Staff asked her to just go a room and lay down so her snoring would not interrupt the movie. Staff had already woke her up several times to participate in watching the movie. After getting to the room, FC #3 decided she did not want to leave the common room. She begin yelling for staff. QPL was in the office at this time listening to the situation.	

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V 512	Continued From page 20 former clients (FC #2). The findings are: Review on 3/31/20 of the QPL's record and interview revealed: - Hire Date: 6/1/05 - Position: Qualified Professional/Licensee - Has a degree and work history that qualifies him as a Qualified Professional. - The QPL stated the APL #2 was his wife. Review on 3/31/20 of the APL #2's record revealed: - Hire Date: 5/12/06 - Position: Associate Professional/Licensee - Has a degree and work history that qualifies her as a Associate Professional. Review on 4/2/20 of staff #3's record revealed: - Hire Date: 3/1/14 - Position: Paraprofessional - Has a degree and work history that qualifies her as a Paraprofessional. Review on 3/31/20 of client #1's record revealed: - Admission Date: 1/24/20 - Diagnoses: Attention Deficit Hyperactivity Disorder; and Disruptive Mood Dysregulation Disorder - Age: 15 years-old - Person-Centered Profile (PCP) updated 1/13/20 revealed: " ...has a history of hospitalizations and a previous group home placement. She also has a history of suicidal ideation and harming herself." Review on 5/7/20 of FC #2's record revealed: - Admission Date: 11/13/19 - Discharge Date: 2/5/20 - Diagnoses: Major Depressive Disorder; Adjustment Disorder; and Post-Traumatic Stress Disorder	V 512	Staffs did go to the room to talk with FC #3. Staff indicated she had tried to stay woke but could not. Staff processed with her about getting sleep and waking up refreshed. FC #3 was walking back and forth when she tripped over her feet and fell. QPL heard the commotion and went to see what had happened. At that time FC #3 was embarrassed and upset. This had become a common occurrence with FC #3 as she was weighing over 220 pounds and was having instances of falling for no reason. Why she said I pushed her I can't explain. However if you just read her responses you can see she was having difficulty understanding the questions. APL #2 could not have said she was going to call the police as she was not even in the facility. APL #2 and QP #2 could not have seen her limping as neither were in the facility on the day of this situation with FC #3. This situation occurred with FC #3 while we were speaking with her social worker about a possible step up in level of care. She spoke with him several times. She never reported anything to him or mentioned being pushed down and hurting her ankle or her arm. She also made no mention to her social worker at the PRTF that she had been pushed down and hurt. According to her social worker, "she calls me about everything". The interview with FC #2 is just not true at all. Her statements are just made up lies. The situation had nothing to do with a stopped up toilet at the other group home. APL #2 could not have put FC #3 in a bedroom for stopping up a toilet because she was not even in the facility when this occurred. The other clients were watching a movie when FC3# fell and FC#2 was never in the hall outside the room to witness anything. She was not in the group home. We would have video, but the cameras were ripped off the wall and destroyed by client A5 before this situation even happened. This is why she is saying she was in the hall. (See photos of destroyed cameras attached.) She knew this because she was calling client A5 her girl friend. Both FC #2 and A5 have demonstrated anger outbursts because they were not allowed to carry on a relationship in the group home. That anger was focused towards APL #2 as would confront them regarding the fact that they could not hug and kiss in the group home. FC #2 had a strange power over client A5.	

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V 512	Continued From page 21 - Age: 16 years-old - Consumer Information: It was noted that she was admitted to Blessed Alms II LLC but an "incident occurred while at BNB (Sister Facility A) on 2/3/2020." - Person-Centered Profile (PCP) updated 1/28/20 revealed: " ...has a long history of receiving services including Outpatient therapy and intensive In-Home services. Client is also involved in DJJ (Department of Juvenile Justice). Client's behaviors have been increasing, which include running away, making threats, highly risky/sexual behavior, fighting, stealing and truancy issues." - Discharge Summary dated 2/5/20 revealed: "She is not responding to treatment by the group home staff or the LPC (Licensed Professional Counselor) who provides her therapy. She is presenting with opposition and defiance as well as severe lying and manipulation and complete non-compliance in the group home setting. She has failed to advance on the behavior management point/level system as she has not made level since her arrival at the group home ...She is over 60,000 points in the negative (with point/level system). This is due to a combination of failure to adhere to the rules and structure and continued involvement in non-compliant behaviors." Review on 3/31/20 of FC #3's record revealed: - Admission Date: 10/28/19 - Discharge Date: 1/8/20 - Diagnoses: Unspecified impulse control Disorder; Disruptive Mood Dysregulation Disorder - Age: 15 years-old - Person-Centered Profile (PCP) updated 12/12/19 revealed: "She has refused to participate in treatment, refused to engage in therapy, demonstrated complete non-compliance,	V 512	It is obvious that FC #2 who initiated this report was trying to cause the agency as much trouble as possible with her lying. All she said was a lie. She was not a witness as she was not even in the group home. She left on 12/20/19. This happened on the weekend of 12/21, 22/19. and Staff #2 and #3 were both in the room when FC #3 fell. FC #2 had her own agenda during her interview, and client A5 was complicit because of her feeling for FC #2. Every staff and other clients knew about the feels between these two. Her statements are lies as she did not return to the facility until 12/29/19. As it relates to the Abuse of FC #2 by the QPL and the APL #2. The first statement in the report which indicates FC #2 was told not to take her dirty clothes home is not true and contrary to what is normal practice in the group home. Any client going home on a visit takes any dirty clothes with them so they can be washed and returned clean when they come back. Most time clients wash their clothes before they go home because visits are on weekends and each client has a wash day during the week. FC #2 was never told she could not take her dirty clothes home, and to leave them in the group home. This is just not reasonable. Upon her return on 02/02/20, she did ask to wash, but she first asked to wash all her clothes. She was reminded that rules was no washing clothes on Sunday. That Saturday was the day designated as an additional wash day. This was just another instance of FC #2 not wanting to follow the rules. This was a regular behavior for her. She then asked about washing underclothes. She was told she could wash underclothes, but had to wait until her wash day to wash her regular clothes. She became extremely verbally aggressive. Stating that she was going to wash all her clothes and she was told no. She was told that she just returned with all new clothes and she had clothes to wear. She responded by saying she had a particular pair of pants she wanted to wear, and told staff she was going to wash her pants, defying staff directives in non-compliance. She carried on so long, cursed so much ("Suck my Dick"; "Motherfucker"; "Bitches"), staff finally told her she could wash so she would not awaken the other clients as she had threatened to do.	

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V 512	Continued From page 22 with open defiance and opposition. She has demonstrated verbal and physical aggression, with some threatening behaviors." - Medical/Dental Concerns: "None reported." - Review of FC #3's Discharge Summary dated 1/8/20 revealed: "[Client #3] is presently a resident in the Blessed Alms II group home ...She is not responding to treatment by the group home staff or the LPC who provides her therapy. She is presenting with opposition and defiance and lying and manipulation. She has been non-compliant in the group home setting. She has continuously failed to advance on the behavior management point/level system as she has not made level since her arrival at the group home ...She is over 40,000 points in the negative (with point/level system). This is due to a combination of failure to adhere to the rules and structure and continued involvement in non-compliant behaviors, refusing to stay away during the day and verbal aggression when she is awakened." Review on 4/2/20 of FC #4's record revealed: - Admission Date: 11/1/19 - Discharge Date: 1/8/20 - Diagnoses: Major Depressive Disorder; Attention Deficit Hyperactivity Disorder; Post-Traumatic Stress Disorder; and Sexual Abuse of a Child (Victim) - Age: 14 years-old - Discharge Summary dated 1/8/20 revealed: "When she was here in the group home she was having small issues with her personal hygiene and wanting to isolate herself in her room ...She had some difficulty learning her goals and rules ...She had some issues with the point/level system and found herself in the negative (with the point/level system) due to inappropriate sexual communication at the day school."	V 512	She returned already angry and in crisis. The guardian was called as she did not even come in when she brought her back. She refused to turn around and come back. We did not know then, but the guardian made a statement to one of my staff that FC #2 had been smoking Hemp all day. That she told her not go back there acting up. At no time did QPL open the bathroom door while FC#2 was inside. Staff #4 was never contacted to verify this. Staff #3 was not working the night of 02/02/20, or on 02/03/20. FC#2 lied during her interview that she washed her new pants. Why would she need to wash her new pants. There is no way for QPL to defend himself against accusation that he pushed open a bathroom door because the new camera system purges itself every 30 days. However, staff #4 who was on duty will testify that QPL never left the couch in the common room while FC #2 was in the bathroom if need be. QPL actually left the facility so that it could not be said that he did anything inappropriate. The following day was a deliberate set up by FC #2 as she waited until APL #2 and QPL showed up at the group home to get out of bed. The rule is that all morning routines are to be completed and clients in the common room by 7:00am. FC #2 deliberately carried over her behaviors from the night before into the next morning. It was obvious that she was prepared to do what ever she had to do the get herself out of the group home. That whole scenario appeared to have been planned by FC #2. She was still in the bathroom after 7:00am. She was verbally aggression and threatening. She refused to leave the bathroom until she had a confrontation with APL #2, who stood outside the bathroom and took the most extreme profanity from FC #2. FC #2 called her a "motherfucking Bitch"; "a cockeyed Bitch; told her to "suck her dick"; and threatened to kick her ass. We have video of the QPL in his office during this and that he came out to find the bathroom situation. He immediately went back in the office and sent a female worker out to assist APL #2. FC #2 tried to say QPL was standing	

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V 512	Continued From page 23 Finding #1: Abuse of FC #3 by the QPL Interviews on 3/31/20 and 5/7/20 with FC #3 revealed: - She was admitted to Blessed Alms II LLC, but indicated the incident occurred at the sister facility A. - In December 2019, before Christmas the QPL pushed her down on the floor. - The QPL, the APL #2, staff #2 and staff #3 were present. - FC #2 and client A5 were there also at the sister facility A. - She was staying in client A6's bedroom alone at the sister facility A. - She had yelled because she did not want to stay in her bedroom. - The QPL came into the bedroom and "pushed me with two hands; I was turned sideways." - She landed on her right arm. She had fallen at a prior placement and was already having problems with her left ankle. - "I was crying after I was pushed down and said to [QPL], 'why did you push me down? You hurt my arm.'" - "My left ankle was hurting afterwards also." - "[The QPL] said I stumbled which was not true." - "I told [the APL #2] and [the QPL] and [QP #2] that my ankle was hurting. They (the QPL, the APL #2, and the Qualified Professional (QP) #2) could tell it was hurting because I was limping. It happened before lunch and I limped until that evening." - "I was taken to the doctor about my ankle. It was not the same day as the incident. The doctor gave me medicine for my ankle for the pain." - Note: medical records from her primary care physician indicated she was seen on 11/14/19 for ankle pain. - The QP #2 took her to the doctor about her	V 512	looking at her in the bathroom when she was taken back to court by her court counselor. He showed video in court to show he did not. The video will show she was not naked when the QPL came out of his office. FC #2 was yelling and cursing, telling APL #2 that she didn't want to be here, she had talked to her aunt and she was going to get her out of her when her uncle got out of prison. That she could not wait until he got out, he was going to take care of us. That she was going to get this place shut down. After she got dressed and fixed her hair, she tried to push her way into the office and take the phone. She wanted to talk to her aunt. so we called her aunt and put the phone on speaker. We were not handing a phone to FC #2 so she could destroy it. However she was able to speak to her guardian and QPL and APL #2 never went in a locked room with the phone. FC #2 was yelling, and cursing, and asking her guardian to come and get her today. She stated she was not going to stay here with these "bitches". The guardian wanted to know what was happening. So we told the on duty worker to speak to the guardian and tell her what was going on. We did not talk to her, so FC #2 could not say we were lying to her. Staff #4 tried to speak with the guardian, but FC #2 yelled and cursed so loud, the guardian said she could not here. We sent the worker to another room. FC #2 chased after her to continue her yelling and cursing. FC #2 chased her and in the process pushed APL #2 into the refrigerator in the kitchen. Staff #4 had to lock herself in the wash room to tell the guardian what was happening. It was when FC #2 pushed APL #2 into the refrigerator that the police were called. There is video of FC #2 chasing Staff #4 and the instant she pushed APL#2 into the kitchen. She was fully dressed and ready, the lights were on in the facility. After the worker clearly told the guardian what was happening and the guardian told her to stop and got off the phone is when FC #2 really became extremely verbally aggressive. She threatened that she was going to call and get this "fucking place shut down" She said she was going to "get all of you motherfucking bitches", and told us to "suck her dick". FC #2 was out of control. She was back and forth yelling and cursing. She went back in the bathroom and would not come out. At that point she was controlling	

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V 512	Continued From page 24 ankle. She was not seen by the doctor about her arm. - After her fall, the APL #2 told her she was going to call the police because she was not listening to them. Interviews on 3/26/20 and 5/7/20 with FC #2 revealed: - She was admitted to Blessed Alms II LLC, but indicated the incident occurred at the sister facility A. - She, FC #3 and client A5 were having down time at sister facility A in December 2019. - FC #3 was in trouble for stopping up the toilet at the other group home. The APL #2 had put FC #3 in client A6's bedroom for stopping up the toilet. - FC #3 kept coming out of client A6's bedroom so the QPL went into the bedroom. - The QPL "pushed [FC #3] on the floor from her left side." She witnessed what occurred as she stood in the hallway outside of client A6's bedroom. - "She got up crying and holding her foot." - "[The QPL] said if she did not get up, he was going to call the police and she would go to jail. I wanted to tell her she did not do anything wrong but I did not want to get involved." - Staff #2 was in client A6's bedroom when it occurred. - Staff #3 came in after the incident occurred. Interview on 4/20/20 with staff #2 revealed: - She denied seeing the QPL push FC #3. - She did not know how FC #3 hurt her foot. - She did not recall QP #2 taking FC #3 to the doctor due to a foot injury. Interview on 4/21/20 with QP #2 revealed: - She could not recall how FC #3 hurt her foot. - "[FC #3] hurt her foot Lord Jesus child I don't	V 512	the house. That is when a decision was made to turn off the lights to gain back control. When the police showed up is when FC #2 walked up on APL #2 and put her hand in her face. This is what the confrontation was about when the police came in. The female officer was new and did not even try to find out what had happened. She immediately had issue with the APL #2 because she was upset that the FC #2 had put her hand in her face. FC #2 was fully dressed and had finished with her as the video shows, however she told the police she needed to fix her hair. The female officer began to tell the APL #2 and QPL what they should do, instead of finding out what the rules were. She asked that the lights be turned back on and they were. She really over stepped her authority. However what she did not say in her interview is that a police supervisor was requested by the APL #2. That one did come out. He was informed of what was going on and he spoke with that female officer. He advised her that the group home had rules, and she could not change those rules. He had her to apologize to the APL #2. There was also another officer present. Also in the female officer's statement she indicated that the QPL told her that the clients had a certain amount of time in the bathroom and if they did not come out, the lights were turn off on them. This is not true. Yes the clients have a certain amount of time to be in the bathroom, because there are four clients that have to complete their personal hygiene routine and dress for school. However the QPL never told her that the lights were turned off if they did not come out. This agency had never turned the lights off on any client until this day. This can be verified with any client that has ever been here. This was used this day to gain back control of the house. As it relates to other client statement; they can not be taken at face value because all other clients were sent to a bedroom during the crisis with FC #2. They could not have witnessed anything as their doors were closed to keep them away from what was going on. The statement from client #1 that the QPL was standing beside the	

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V 512	Continued From page 25 even remember how it happened. She liked to run up and down the hill that's probably how she did it." - Recalled taking FC #3 to the doctor but could not recall the reason FC #3 was taken to the doctor. - "I don't really remember so maybe we need to talk about something different." Interview on 4/22/20 with the QPL revealed: - He did not know for sure how FC #3 hurt her foot in December 2019. - Denied he pushed FC #3 - "[FC #3] was running up and down the hill at Blessed Alms ...[FC #3] hurt her foot at [prior placement]. [FC #3] said she slipped on the stairs at Blessed Alms" - "We didn't do an incident report. [FC #3] said she slipped on the steps that was all." Review on 4/27/20 of FC #3's medical record from her primary care physician revealed: Date: 11/14/19 - "Here for f/up (follow-up) and review today. C/O (Complaining of) right ankle pain ongoing for a month after falling in the shower, improving but still present - exam unremarkable except for minimal tenderness - supportive pain control." - Date: 11/21/19 - "Patient is brought in today because she accidentally fell at home and has some abrasive injuries on her right lower legs. No active bleeding noted. Aggressive injuries are clean and caregiver and patient advised on hygienic cleansing of wounds with prescription of triple antibiotic dressing changes advised." - No documentation of treatment related to an injury that may have occurred in December 2019 Finding 2: Abuse of FC #2 by the QPL and the	V 512	APL #2 in the hallway, is disproved by the video provided. The female officer in her statement was speaking her opinion, not facts. The things she states in her interview are not in the police report. The police report describes what FC #2 was wearing and it shows she was fully dressed and ready, not what FC #2 says in her statement. If there was abuse involved in this case, it was FC #2 that perpetrated it. No one ever touched her. She chased staff #4, she pushed APL #2 into the refrigerator, she put her hands in the APL #2 face, she was verbally aggressive with the use of extreme profanity, and she threatened to shut the group home down, and carried out that threat. That is why we are going through this presently. Neglect of FC #2 by the QPL: The QPL did not know of this until 01/22/20. FC #2 had successfully hid this from the group home for multiple days, and had no intention of the group home becoming aware of it. When the LCMHC-S caught a glimpse of it and asked what it was she had on a long sleeve shirt trying to hide it. She ha went these days without mentioning any type of pain. When the staff informed the APL #2 of what they had found, the APL #2 told staff they could take her to the Urgent Care. FC #2 stated she did not want to go to the doctor. This is her right, the group home can't make her go. The picture sent to the QPL showed no swelling or bleeding. It looked like a tattoo. This is the desired look she was trying to get. The photo was immediately sent to the guardian on 01/22/20. The text sent to the guardian indicated; I sent these to show you what FC #2 did to her arm with a pencil. I told her she needed to tell you what it is and why she did it. She has to talk to you about it. We can talk after she calls you. The guardian never texted or called me back. She called FC #2 and cursed her out. She called it "devil worship". The guardian did not ask staff to take her to a doctor. You could look at the tattoo and she it had been there for some days.	

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V 512	Continued From page 26 APL #2 Interviews on 3/25/20 and 3/26/20 with FC #2 revealed: - She was admitted to Blessed Alms II LLC, but the incident occurred at the sister facility A. - She returned to the group home from a home visit on Sunday (2/2/20) around 7:30 pm. - The QPL and staff # 4 were present when she returned to the group home. - Client A5 and client A6 were also present. - Prior to going on her home visit, she asked the APL #2 if she should take her dirty clothes home with her and the APL #2 instructed her to leave her dirty clothes at the group home. - On 2/2/20, when she came back to the group home, she asked staff #4 if she could wash her undergarments because she did not have any clean undergarments. She also asked staff #4 if she could wash her new pants. - She knew that "wash day was Wednesday. Only [the APL #2] could give permission to allow you to wash clothes on Sunday." - "[Staff #4] said I could wash my clothes and [the QPL] said, no I could not wash my clothes. [The QPL] said [the APL #2] is not here, so no." - There continued to be a lot of discussion between her and the QPL about washing her clothes. - "I did wash my new pants in the bathroom sink and ...[the QPL] pushed the door open. [The QPL] said, no you are not washing your clothes. I said ok well I have to use the bathroom and [the QPL] said I was not using the bathroom. He never moved out of the bathroom. I finished washing my pants while he stood there in the bathroom. [The QPL] left the group home and I asked [staff #4] to put the pants in the dryer and she did. Then I went to bed."	V 512	FC #2 was offered the opportunity to go to a Urgent Care to see a doctor, she refused. We met our obligation when we found out. If the QPL was neglecting FC #2 why didn't the guardian call in a report when she saw the cutting on 01/22/20. She never asked the group home to take her to a doctor. Why is the guardian not being substantiated on for neglect, as she did not say take her to a doctor. Abuse of client #1 by the QPL: This is just a ridiculous situation. The word slam should not used here. The QPL simply attempted to close the door. Client #1 put her foot in the door to keep him from closing it. To label this as abuse demonstrates an inherent bias on the part of the investigator. Abuse has to be demonstrated by a deliberate act. There was no deliberate act on the part of the QPL. He simply tried to close the door. It was client #1 that deliberately stuck her foot in the door. She just appeared to be having fun keeping the door open and trying to get to the QPL. This is what she later said to staff. She was never hurt as photos will show.	

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V 512	Continued From page 27 Continued interviews with FC #2 on 3/25/20 and 3/26/20 revealed: - She had asked staff #4 the night before to be the first one to take a shower because she did not want to be last because the water would be cold. -When she woke up the next morning, client #1 was already in the shower so she just went back to sleep. - When she woke back up, it was close to 7am which is the time she is supposed to be ready for school but she went ahead and got in the shower. The APL #2 arrived at sister facility A. - "I got out of the shower at 6:57 am. I heard [the APL #2] knock on the door and say, 'you need to get out of the bathroom now. I was like ok.' - "I just stepped out of the shower and had no towel on. [The APL #2] said, 'are you yelling at me' but I was not yelling ...I said, 'do you want me to come out of here naked?' [The APL #2] pushed the door open and I had nothing on. I looked and [the QPL] was standing right beside of [the APL #2]. I looked in the mirror and I see [the QPL] and then I looked at him and locked eyes with [the QPL]. [The QPL] walked away and said he was not supposed be there. - "I was mad and I cursed at him ...I pulled the door closed and [the APL #2] was pushing her body against the door to keep it open so I grabbed my towel and put it around me. I started crying and I was screaming call my [Legal Guardian (LG)]." - "I kept crying and screaming. [The APL #2] said 'I am going to call [LG], but you can't talk to [LG].' I said 'my [LG] will hear me.' [The APL #2] dialed the phone and put it in her pocket. [The APL #2] and [the QPL] went into another room and closed the door with the phone. I was screaming outside the door, '[LG], [the APL #2] had the door open and I didn't have any clothes on and [the QPL] was standing right there.'"	V 512		

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V 512	Continued From page 28 - "I guess [LG] could hear me and my [LG] said to put her on speaker and let me talk to her. My [LG] told me to go get dressed and she was not going to listen to me scream but to call her back when I finished getting ready." - She then attempted to finish getting ready. - "I went in the bathroom ...I was brushing my teeth and had water in my hand [the APL #2] turned the water off and then turned the light off. [The APL #2] said, I want you sitting in the living room with her and the other girls. I said I am already late and you won't let me talk to my [LG] and I need to get ready. [The APL #2] then went and turned off the breaker and all the lights went out. [The APL #2] called my [LG] again. [The APL #2] told my [LG] I could not stay in her group home anymore and she was going to do some type of paperwork." - "[The APL #2] called the police and was stomping around the house. She talked like a cheerleader, she was clapping her hands and stomping her feet and saying, 'I am not scared, I am not scared.' Then I tried to put my wash rag and towel in the laundry room. She put her arms across the doorway to block me from getting into the laundry room. I said to [the APL #2] 'can you please move?' I finally ducked under her arms and walked into the laundry room and [the APL #2] said that is assault that I pushed her. She called the police again and said she had a '16 year-old juvenile who put her hands on me.' " - When the police arrived, they asked, "[the APL #2] why she was yelling and asked why it was dark in the house?" - "The police said to [the APL #2], 'you are preventing this child from getting ready for school.' [The APL #2] said to the police, she could not tell her what to do in her group home." - FC #2 finished getting ready while the police were present and then went to school.	V 512		

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V 512	Continued From page 29 Interview on 4/7/20 with Client A6 revealed: - She resided in the sister facility A where the incident involving FC #2 occurred. - FC #2 came back from a home visit on a Sunday and told staff she had no clean undergarments to wear. She, client A5, and client A7 were present along with the QPL and staff #3. - Sunday was not "wash day." - The QPL told FC #2 she could not wash her clothes. - "It was Sunday and they didn't want us to wash clothes on a Sunday. Even though we don't do anything on Sunday I think we should be able to wash our clothes for school on Sunday." - The following day (Monday) FC #2 spent over 10 minutes in the bathroom getting ready for school. - "[FC #2] still had to brush her teeth and do her hair. We only get 10 minutes in the bathroom. You have to be in the common area at 7 am. [The APL #2] got upset, she told [FC #2] she needed to be in the common area at 7 am and told her she lost 1500 points. [The APL #2] shut off the main breaker in the house and then the cops were called." - "The female officer told [the APL #2] to turn on the breaker so that [FC #2] could finish getting ready for school. [The APL #2] told the officer this is my house and she is going to follow my rules and not go over 10 minutes in the bathroom." - "I was in my room at the end of the hallway and it sounded like [the APL #2] was yelling at the officer." Interview on 4/1/20 with Client #1 revealed: - She was in her bedroom when the QPL opened the bathroom door and FC#2 was in the bathroom. - The APL #2 was standing beside of the QPL	V 512		

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V 512	Continued From page 30 when he opened the bathroom door. - She was unable to see inside the bathroom but FC #2 stated "[FC #2] was half dressed." Interview on 4/22/20 with the QPL revealed: - He worked the evening of 2/2/20. - FC #2 came back from a home visit on 2/2/20 with new clothes and wanted to wash a pair of pants. - He and staff #3 were on duty. He could not recall the other clients who were present. - "We (the QPL and staff #3) told [FC #2] no you can't wash clothes. We went back and forth about that one pair of pants and I finally said go ahead and wash the pants. Interview on 4/22/20 with the APL #2 revealed: - She worked the morning of 2/3/20. - On 2/3/20 FC #2 was late getting ready for school. - When FC #2 did not get up on time and took too much time in the bathroom getting ready. - FC #2 had been in the bathroom for "20 minutes." - The clients have to be in the common room by 7 am for group time. - "The only way I could get [FC #2] out of the bathroom was to turn off the lights so I turned off the lights. I asked the others to go to their rooms. [FC #2] came out cussing. That's when I told her I was going to call the police because this is getting way out of hand this is crazy." - "When the police lady came, [FC #2] rushed to tell her story. [FC #2] and I were talking at the same time and police lady told me to be quiet. [FC #2] told her side and the police lady told me to cut on the lights and said don't you want her to go to school. The police lady's priority was getting [FC #2] to school. I said she is not compliant with anything. The issue was not her being ready for	V 512		

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V 512	Continued From page 31 school, the issue was she was not compliant with any of our directives and she was verbally and physically aggressive. Our directives were to get her out of the bathroom and sitting down compliant with everyone else. [FC #2] made a big issue out of all of this." Interview on 4/22/20 with a local Police Officer revealed: - She responded to a call from the group home on 2/3/20. - "I remember specifically [the APL #2] on scene was not happy and ended up apologizing to me." - "They (the APL #2 and FC #2] were yelling at each other. I said to [the APL #2] to stop yelling. I talked to [the QPL] about what was going on. [The QPL] said they (the clients) have so many minutes to get ready and then when they go over that time, they turn the electricity off on the clients. [FC #2's] hair was not done. I said, 'isn't it better for the child to finish getting ready for school than to argue and let her be truant for school?' " - The Officer requested the APL #2 and the QPL turn on the power. The APL #2 then got upset with her. - "I asked [FC #2] to get ready for school and she finished getting ready." - She asked if the APL #2 and the QPL had been trained and the QPL said they were both trained in counseling. - "I asked (if they were trained) because they [the APL #2 and the QPL] were bantering back and forth with [FC #2]. I felt [the APL #2 and the QPL] were baiting [FC #2], pushing her buttons and then blaming [FC #2] for being disorderly. They were stalling her by keeping the power turned off. [FC #2] was at first in a heated argument and when I solved the issue, she was completely compliant."	V 512		

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V 512	Continued From page 32 Review on 3/27/20 of Incident Response Improvement System (IRIS) revealed: - Date of Incident: 2/3/20 - Date last submitted: 2/5/20 - Name and Title of person completing this form: [The QPL], Director, QP - "The consumer started her non-compliance on Sunday night when she came back from a home visit to get clothes. She came in angry and first refused to comply with the procedure to inventory any new items brought into the group home. She became even more angry when told she had to bring the new items from her room to be inventoried. The group home did not know why she was angry, but we suspected that she just did not want to come back to the group home. She had acted like this before after a visit. She however did not calm down, and became verbally aggressive using extreme profanity and refused to comply or engage in treatment at all. bedtime was at 8:00, she refused to go to bed and set in the common room until 10:00 before we were finally able to get her to go to bed. This behavior carried over into the next morning. She refused to get out of bed as she was the first to be prompted. She refused to get up and eat or take her medication. The rule is that all consumers have their morning routine completed, be dressed and sitting in the common room by 7:00. This consumer was at this location because she got back late and a decision was made to allow her to spend the night. However she was aware the the rules are the same at both of the group home. She did not get up to shower until 7:15, she did this deliberately and it caused disruption in the scheduling. When confronted by the on coming shift, she became verbally aggressive and called staff very profane name you could think of. She was totally non-compliant and refused to process	V 512		

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or engage in her treatment. She demanded to talk to her guardian. The oncoming staff had the overnight staff speak with the guardian to let her know what was going on. the consumer became extremely aggressive, to the point of pushing her way into the office and trying to take the phone. The staff had to go to a locked wash room to speak to the guardian. this was after the phone was put on speaker for the guardian to speak to the consumer. When the staff tried to go the locked wash room to speak to the guardian due to the consumer being so verbally aggressive. The consumer physically put her hands on the morning staff and pushed her. At that point the police were called. The police arrived and the consumer tried to push her way out the door. Staff intervened and waited for the police to come in. The female officer stood between staff and the consumer as the consumer had put her hand up in staff's face. The officer heard the consumer first. She then attempted to tell the group home staff how she thought they should handle the situation. A police supervisor came to the scene, and told his officer that she should have not intervened that way. That the group home has rules and she should have not suggested them not following their rules. The officer apologized to the group home. She had never handled a call to the group home. This empowered the consumer as she began to make threats as she had the night before that she was going to get the group home shut down. she told the staff to suck her d**K, that all the staff were m****r f*****s, b******s and many other curse words, and she was going to get them all, she was shutting the group home down. It took some time, but staff was able to get her calmed down to go to school. The director check the group home website for referral, and found that someone had actually went the site, pretended to make a referral and had used all the

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V 512	Continued From page 34 exact same profane words the consumer used in the group home. They had also threatened to shut the group home down. The next morning the consumer started the same behavior with provocation. Staff finally had to ignore her to get past the episode and get her to school. There is a conference meeting scheduled for 02/05/20 at 11:00am to address this case." Finding #3: Neglect of FC #2 by the QPL Interview on 3/24/20 with FC #2's LG revealed: - She was admitted to Blessed Alms II LLC, but the incident occurred at the sister facility A. - On 1/22/20 she had received a text from the QPL that contained pictures of FC #2's forearm. - She could see the engraved word "Die" and symbols covered most of inside area of FC #2's forearm. - It was reported to her that FC #2 did this because "no one listened to her." - She asked the QPL if he had taken FC #2 to the doctor and he responded: "by the time, we saw it, we didn't think she needed to go to the doctor." - The cut word and symbols were still visible on 3/24/20. Interview on 3/25/20 with the QPL revealed: - FC #2 was admitted to Blessed Alms II LLC but was moved to the sister facility A due to having "issues." - He was unable to provide a date for when FC #2 was discharged and admitted to the sister facility A. Review on 3/25/20 of Pictures Provided by FC #2's LG revealed: - The pictures were noted by FC #2's LG as taken on 2/6/20 by FC #2's LG.	V 512		

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V 512	Continued From page 35 - The pictures were noted by FC #2's LG as pictures of FC #2. - One picture was of a forearm covered almost fully with cut symbols and the word "Die." Interview on 3/25/20 with FC #2 revealed: - She could not recall the date when she cut the word "Die" and other symbols on her forearm but knew it was a Sunday after she returned from a group home outing at a local Science Center. - She was never seen by a medical provider after staff had seen the cut marks on her arm. - "I drew it with a pen at first and then carved the picture into my skin with a lead pencil." - "I knew if I drew it someone would notice because the whole time, I was there my [LG] was not listening to what they were doing. I knew if she saw that she would ask why I did that because I have never cut myself before." - "[The QPL] and all the staff saw it throughout the week. That Saturday [staff #3] put some alcohol on it because it was a big scab and it was bleeding." Interview on 4/17/20 with the Licensed Professional (LP) revealed: - He noticed the cut word "Die" and other symbols on FC #2's arm just as he was leaving the group home one evening. - He had staff #3 contact the QPL and the APL #2 to let them know what was on FC #2's arm. - He was unsure if the QPL or APL #2 took her to a medical provider. - "She was fine and upbeat and not thinking of harming herself or others." Interview on 4/20/20 with staff #3 revealed: - She and the LP observed the cut word "Die" and other symbols on FC #2's arm sometime in January 2020.	V 512		

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V 512	Continued From page 36 - She contacted the QPL and sent him pictures of FC #2's arm. - The next day FC #2 complained her armed hurt. She contacted the APL #2 and asked if she should put peroxide on the FC #2's arm. The APL #2 told her she could. - "It was ugly looking. It had not scabbed up yet. It had that fresh look, it was red." - "It didn't look bad enough to go to hospital but I am not a doctor." Interview on 4/22/20 with the QPL revealed: - He did not know when FC #2 engraved the word "Die" and other symbols on her arm. - FC #2 engraved the word "Die" and other symbols on her arm while at school. - Peroxide was put on the wound by staff #3 "because [FC #2] was picking at it." - FC #2 was not seen by a medical provider for the wound. - "It was discovered. It had healed over. She never complained about pain." Finding #4: Abuse of client #1 by the QPL Interview on 4/1/20 with client #1 revealed: - She was admitted to Blessed Alms II LLC, but the incident occurred at the sister facility A. - She slept over at the sister facility A "a lot of times." - The clients from Blessed Alms II LLC would sleep over at the sister facility A when only 2 clients were in Blessed Alms II LLC. - Sometime in March 2020, she, the APL #2 and the QPL had been arguing and the QPL slammed her foot in the front door. Client A6 was also present. - "I was standing at the front door and [the QPL] kept trying to close the door. I would not move so he kept slamming my foot in there (the door)."	V 512		

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V 512	Continued From page 37 - "My foot was hurting a little afterwards because I had crocs on." Interview on 4/7/20 with client A6 revealed: - Sometime in March 2020, client #1 stood at the front door and the QPL slammed the door on her toes. - "She told [the QPL] she was going to call the cops because it hurt and she was going to press charges. The cops were called." Interview on 4/22/20 with the QPL revealed: - Sometime in March 2020, client #1 stood next to the front door. - He told client #1 that "we could not stand here and let all the heat out." - He closed the door 3 or 4 times when client #1 "stuck her foot in the door." - He called the police. - "Every time I tried to close the door [client #1] would stick her foot in the door. She stuck her foot in the door because she was mad about something. I was just trying to close the door. She had on crocs. " - "She never complained about her foot being hurt." - An incident report was not completed. Interview on 4/22/20 with the APL #2 revealed: - She was in another room when the QPL closed the door on client #1's foot. - The police were called and she heard client #1 tell the police the QPL closed the door on her foot. - "I kept hearing [the QPL] tell [client #1] to get out of the front door so that he could shut it because it was cold that day. [Client #1] wanted to walk out. She was upset and she wanted to go outside."	V 512		

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V 512	Continued From page 38 Finding #5: Abuse of FC #2, FC #3, and FC #4 by the APL #2 Interview on 4/2/20 with FC #4 revealed: - The APL #2 told client A7 that she "was going to physically fight [client A7]." - The APL #2 would cuss at client A7 and client A7 would cuss at the APL #2. - The APL #2 would state to client A7, "if you hit me, I have the right to hit you back." - The APL #2 called all the clients "dumb almost every single day and call us s***s." Interview on 4/16/20 with FC #2 revealed: - The APL #2 often cussed at the clients. - "Yes, [the APL #2] cussed all the time. To be a Christian woman she cussed all the time. She would get in our face and say: 'We got her f'd up and this is her d**n group home and we can't tell her what the h**l to do in here.' " Interview on 4/17/20 with FC #3 revealed: - The APL #2 cussed at her and the other clients. - "[The APL #2] would say I don't give a D who they tell. [The APL #2] would threaten [Client A7] if she put her hands on her first, she would hit her back." Interview on 4/17/20 with FS #7 revealed: - She had heard the APL #2 cuss in front of the clients more than once. Interview on 4/22/20 with staff #3 revealed: - The APL #2 got in the clients' faces and yelled at them. - The APL #2 repeated back cuss words that the clients stated. - "[The APL #2] does get into the kids face and yells at them. I know she did do it with [FC #2] and with [client A5]. I know she provokes them.	V 512	Abuse of FC #2, FC #3, and FC #4 by the APL #2: This is basically not true. APL #2 has been kicked, punched, her glasses slapped off her face, spit on, pushed down. She has endured so much over her 15 years here. Yet she has never retaliated. This group home clients has been the most difficult to deal with that has ever been in the group home. It became such an everyday thing that the APL #2 tried to figure out how to address it. Just processing was not processing anymore. FC #2 especially as she never made any progress during her time in care. She cursed like a sailor all the time with no remorse. FC #3 we tried to work the most with, because of her IDD needs relate to her low IQ. FC #4 never had real out of control behavior, she is just repeating what she had heard from the other clients. The APL would just stand up to them. She would not let intimidate her and they did not like it. She stood her ground and when they cursed at her, she would tell them do you hear yourself. She reminded them that they would not be in the group home the rest of their lives, and what will you do when someone calls you; and she would repeat to them the things they said. This is the context she used any profanity. APL has never threatened to fight clients. She would just let them know that she has been trained in therapeutic hold techniques, ans she would use them if she had to. The clients were the ones who got in her face, she just never ran from them, even though she was smaller than most of them. Abuse of FC #3 by the QPL and the APL #2: There are so many lies in the statements taken here. If any of these clients had to appear in a court of law they would all be held in contempt for purgery. None of them know what happen with FC #3. She did not want them to know she wet the bed every night. She never had a room mate the entire time she was here. This is the truth as it happened. FC #3 had a severe bed wetting problem So severe she was on medication for it, (Desmopressin Acetate). She was in a double room with tow beds. She said she was afraid of the dark and that is why she did not get up at night	

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V 512	Continued From page 39 The staff has said on shifts that I didn't work that [the APL #2] caused the incidents with the kids. The staff would say she would argue with clients. When you scream and holler at the kids it escalates things." - "[The APL #2] will repeat back what the kids will say. The kids will say, 'I don't give a f**k and she will say that is the point, you hear that [staff #4] she doesn't give a f**k." Interview on 4/22/20 with the APL #2 revealed: - Denied that she threatened to physically fight client A7. - Denied that she cussed at clients but repeated cuss words clients might say. - "I might say to staff she said she doesn't give a f**k. I repeat what they say." Finding #6: Abuse of FC #3 by the QPL and the APL #2 Interview on 3/31/20 with FC #3 revealed: - She was admitted to Blessed Alms II LLC, but the incident occurred at the sister facility A. - The APL #2 would take the mattress off the bed she slept in at sister facility A because she slept too much. - "I was just tired there and gave up on that place so I slept all the time. They were not helping me there." Interview on 4/16/20 with client A7 revealed: - FC #3 slept at both Blessed Alms II LLC and the sister facility A. - FC #3 "had accidents in her bed." - One time the QPL took FC #3's mattress and put it in the hallway. - The APL #2 then came into the group home and stated, "I have already talked to [FC #3] about this (wetting the bed)." The APL #2 took FC #3's	V 512	To help her the light was left on at night for her. She was wetting the bed she slept in, then going over to the empty bed and wetting that one also. To save the mattresses a plastic cover was placed over the mattress she slept on and the mattress on the empty bed was removed and placed in storage. That is all that was done. FC #3 had a mattress day and night in the facility. Don't know how the question was posed to FC#3, but she told the internal investigator she always had a mattress. As far as her just being tired and giving up here. She cried when she had to leave, and begged if she got herself together, could she come back. She begged us not to send her away and give her another chance. As it relates to our sister facility, there has never been a mattress removed from the facility. FC #3 only visited there. Don't know why a client would say a mattress was removed there, but only to lie and cause the agency trouble. FC #3 would sleep a lot. That was on the couches and in single chairs at anytime of the day. However, she slept on a mattress each time she was in her bed. It makes no common sense to do what is being substantiated here. All the investigator had to do was contact the social worker. FC #3 called him about every thing. We are sure she would have told him if she slept on the floor for 3 weeks, and he is too. He was never called about this by the investigator. Abuse of FC #3 by the APL #2: This is another situation of what appears to be bias on the part of the investigator. FC #3 came to this agency already on 300mg of lithium Carbonate. She was 104 pounds over weight and was thirsty all the time. We first allowed her to drink extremely large amounts of water. She started wetting the bed some days. However being allowed to intake large amounts of water in the day and at night. She began to wet the bed every night. Her mattress had to be sanitized everyday. We still allowed her to have a large intake of water during the day, but when she requested water every ten minutes or so we would tell her not to drink the whole glass at one time. She could go back and finish the glass. She was still able to drink water during the day. We went from 10/28/19 to december before we started	

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V 512	Continued From page 40 mattress and put it in a building behind the sister facility A. - "[FC #3] did not have a mattress to sleep on, she slept on the floor. [FC #3] slept on the floor for about 3 weeks." Interview on 4/20/20 with FC #4 revealed: - The QPL and the APL #2 took FC #3's mattress "because she kept wetting the bed." - "[FC #3] would sleep on the wooden dresser thing, she would lay on the wood with her covers and pillow or in a chair. We did not share a room but I would walk past [FC #3's] room and see that she would sleep like this." Interview on 4/22/20 with the APL #2 revealed: - FC #3 would wet the bed at night. - FC #3 slept in a room with two single beds. The second bed was not being used. - Denied that FC #3 had her mattress taken from her. - FC #3 placed the unused mattress on top of her mattress and urinated on the unused mattress. - "We told [FC #3] could have the bottom mattress (her original mattress) or the one she was peeing on. I told her that. She had never, not had a mattress." Interview on 4/22/20 with the QPL revealed: - FC #3 was in a bedroom with two single beds and no one was sleeping on the other bed. - FC #3 was sleeping on the other mattress due to her nocturnal enuresis problem. - "She was sleeping on the other mattress so she would not pee in her own bed." - "We removed the mattress from the second bed." Finding #7: Abuse of FC #3 by the APL #2	V 512	limit her water intake just before she went to bed. This was after meeting with her social worker and advising her care coordinator. The social work supervisor who took over the case after the social worker left was also aware of limiting FC #3 water intake after 7:30pm. She went to bed at 8:00pm. How this could be classified as abuse when this was an effort to help this client. Both with her bed wetting issues and her self esteem. Plan of Correction: As it relate to abuse or neglect by the QPL and APL #2. QPL and APL #2 will no longer work shift work in the group home. They will no longer have direct contact with any client. The QPL and The APL #2 will only work in human services, financial, recruiting of staff, with placement providers and medicaid billing. This measure will address any hands on counseling by the QPL and The APL#2. As it relates to staff #3; she and all current staff will be trained in sensitivity and de-escalation by the LCMHC-S to address the action in this report. This will be done as soon as the LCMHC-S has developed his curriculum. The new program manager and LCMHC-S will monitor the facility monthly to ensure no staff is engaged in any actions in this report. This will ensure this never occurs again.	

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V 512	Continued From page 41 Interview on 4/23/20 with FC #3 revealed: - She was admitted to Blessed Alms II LLC. The incident occurred at both Blessed Alms II LLC and the sister facility A. - She was limited by the amount of drink she could have by the APL #2. - The APL #2 would pour the water for her. The APL #2 provided a half cup of water/liquid at a time. - There were times when she was thirsty and she would drink water out of her bathroom sink. Interview on 4/22/20 with the APL #2 revealed: - Prior to being admitted, FC #3 took medication for nocturnal enuresis. - When FC #3 was admitted, she called FC #3's prior placement but the medication for nocturnal enuresis was never sent. - She and other treatment team members decided to limit FC #3's intake of water/liquids during the day and did not allow FC #3 to drink liquids after 7:30 pm. - Did not know if any staff who took FC #3 to the doctor ever talked to the doctor about FC #3's nocturnal enuresis. Interview on 4/27/20 with the QPL revealed: - He had no treatment team meeting notes with regards to decreasing FC #3's liquids during the day and stopping liquids at 7:30 pm. Interview on 4/23/20 with the Collateral Contact at FC #3's current placement revealed: - She currently worked with FC #3 in a mental health facility. - FC #3 came to her current facility on Lithium that was prescribed while she lived at Blessed Alms II LLC and the sister facility A. Lithium caused her to drink a lot. - When FC #3 was admitted to her current	V 512		

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placement, she used the bathroom 5-6 times at night.
- FC #3's current psychiatrist took her off Lithium. Since that time, FC #3 went to the bathroom sometimes 1 time a night.

Finding #8: Verbal abuse of FC #2 and FC #4 by staff #3

Interview on 4/16/20 with FC #2 revealed:
- She was admitted to Blessed Alms II LLC. The incident occurred at both Blessed Alms II LLC and the sister facility A.
- Staff #3 threatened to hit clients.
- "[Staff #3] said if some child puts their hands on me, 'I am not scared to hit them back.' She said she would not let no child hit her."

Interview on 4/2/20 with FC #4 revealed:
- She was admitted to Blessed Alms II LLC. The incident occurred at both Blessed Alms II LLC and the sister facility A.
- Staff #3 threatened to hit clients.
- "[Staff #3] said she was not afraid to get in trouble for getting into a physical fight with any of us. She said if any of us hit her she was not afraid to hit us back."
- Denied staff #3 ever hit a client.

Interview on 4/20/20 with staff #3 revealed:
- Denied that she threatened to hit clients.
- "I think that is wrong to be asked because it is a lie."

Review on 5/11/20 of the Plan of Protection dated 5/11/20 written by the Licensed Professional revealed:

"What will you immediately do to correct the above rule violations in order to protect clients

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V 512	Continued From page 43 from further risk or additional harm? Initial provision of the plan of protection will be that all staff involved in the above sited violation will immediately cease to work in the facility until an internal investigation has been completed and an investigation by the Health Care Registry has been completed. In addition: -No staff of the agency will push, or physically engage any client while they are in bed, or for any other reason. -Cutting off lights will never be used to address a client's refusal to adhere to getting dressed in the scheduled time allowed. -No staff will approach a bathroom door when a client is refusing to get ready and exit in a timely manner. -Staff will immediately seek medical attention for all clients with even what may be considered minor medical issues. -If a client is sleeping in a non-designated area, staff will not touch the client, but address this issue with the point/level system. -If a client impedes the closing of a door with her foot, the door will remain open until therapeutic interventions with the client can get her calmed down and out of the doorway. -All client mattresses in all bedrooms of the facility will remain in place and never be removed even there is no client in the bed, or for any reason by staff. -During Child and Family Team meetings, medical providers will be considered to address potential medical issues, i.e. enuresis, before implementing subsequent interventions. -No staff will communicate with a client in a threatening manner for any reason at any time. This includes the use of swear words. Describe your plans to make sure the above happens. The LCMHC-S (Licensed Clinical Mental Health	V 512		

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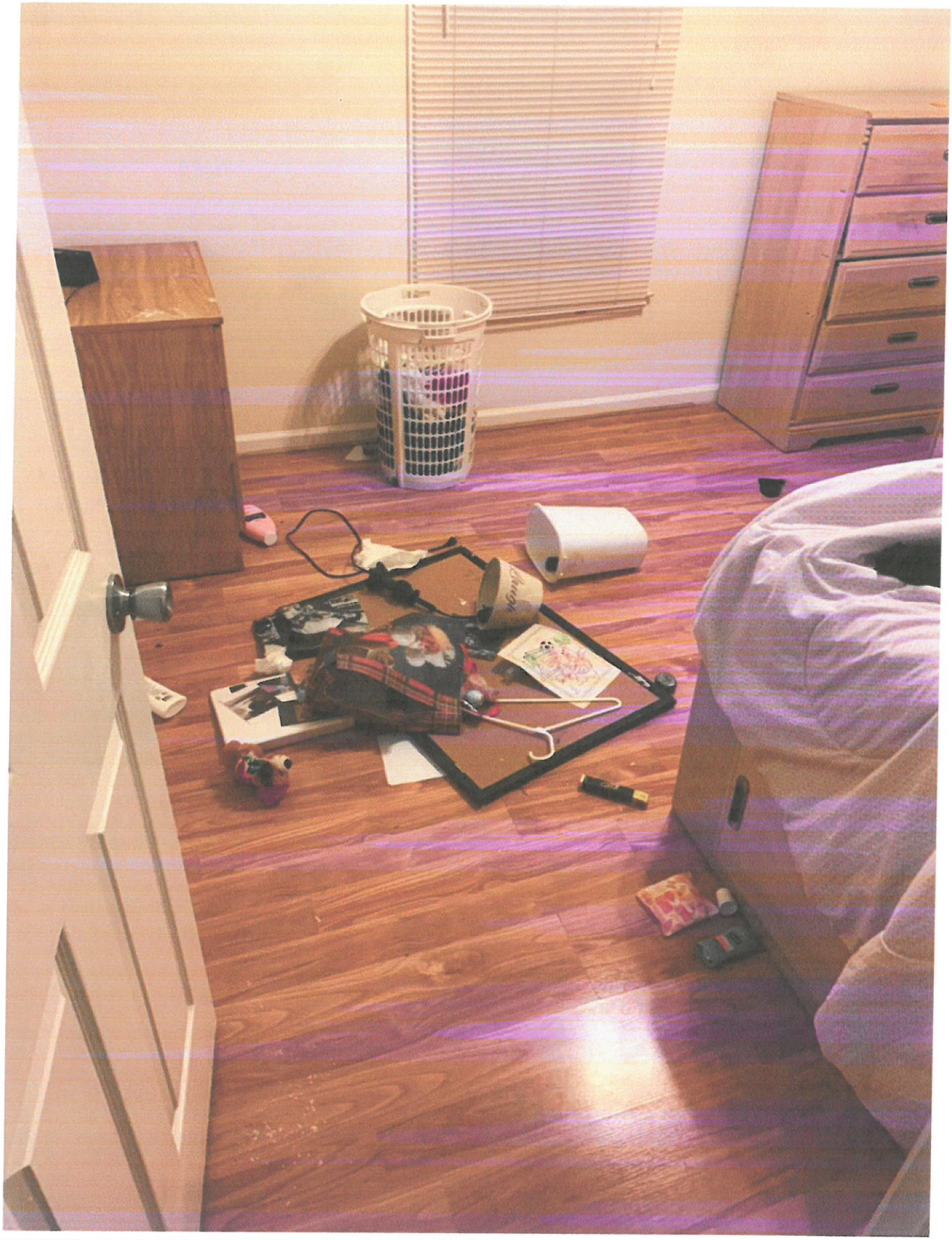
V 512	Continued From page 44 Counselor Supervisor) will immediately meet with and familiarize the staff of this protection plan. He will ensure that he orients the acting manager of the plan and her responsibility to hold the staff working with the clients responsible for adhering to the protection plan that is to be implemented immediately. It will be documented in the daily log that all provisions of the protection plan were monitored daily by the acting manager to verify that they were adhered to. A copy of this protection plan will be posted in each staff's box and in the daily log for staff's attention." The incidents at the facility involved 4 female clients (1 current client, and 3 former clients) ages 14, 15, and 16, with various diagnoses not limited to: Attention Deficit Hyperactivity Disorder; Disruptive Mood Dysregulation Disorder; Post-Traumatic Stress Disorder; Sexual Abuse of a Child (Victim); Unspecified impulse control Disorder; and Major Depressive Disorder; Adjustment Disorder. Treatment plans and discharge summaries revealed clients struggled with issues of: suicidal ideation, runaway behaviors, risky sexualized behaviors, fighting, stealing, making threats, truancy issues, and defiance. There were 7 different incidents of abuse that occurred and 1 incident of neglect that occurred at the sister facility A. Five of the abuse incidents and neglect by the QPL included: he did not allow a client to wash her clothes; pushed open a bathroom door to a client who was not dressed because a client was taking too long getting ready; did not obtain medical attention for a client who engraved the word "die" on her arm; slammed a client's foot in the door who would not move; and took the mattress of a client due to nocturnal enuresis which resulted in her sleeping on the floor. The APL #2, who is the Licensee's wife was involved with 4 of the abuse incidents.	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411083	A. BUILDING: _____ B. WING _____	05/21/2020

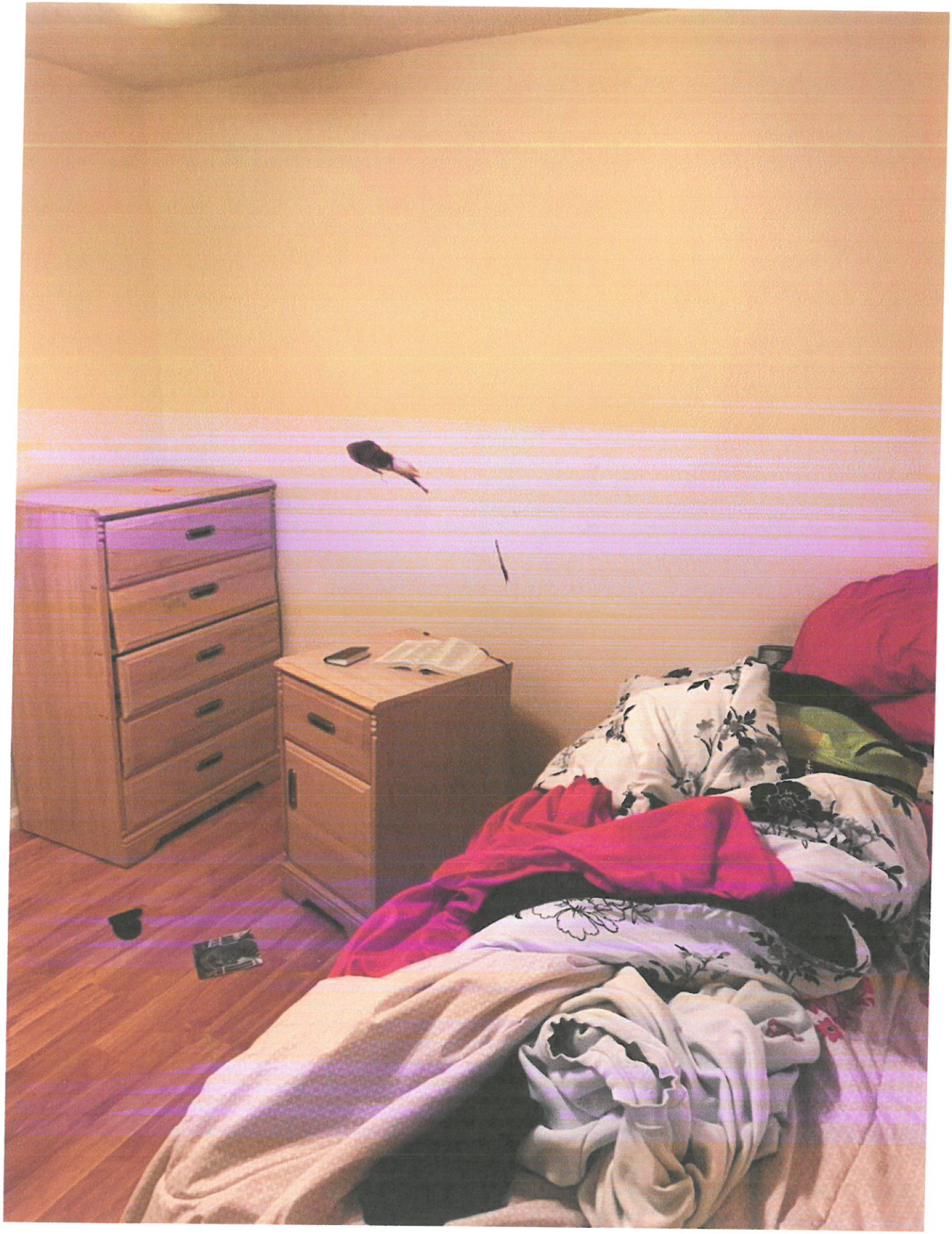
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED ALMS II LLC	3909 BEARS CREEK ROAD GREENSBORO, NC 27406

(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 45 Abuse by the APL #2 included: she turned off the main breaker on the group home to get a client out of the bathroom; she stood beside the QPL when he pushed open the bathroom door on a client who was not dressed and was taking too long in the bathroom; cussed at clients and threatened to fight a client; took the mattress of FC #3 due to nocturnal enuresis which resulted in her sleeping on the floor; and decreased the liquids of FC #3 who was taking Lithium and drank a lot due to the medication without consulting a medical provider. Staff #3 was involved with 1 abuse allegations. Abuse by staff #3 included: threatened to hit clients. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 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		



BOARDS TORN FROM WALL
LAMP AND RADIO DESTROYED
HOLES IN WALL

FC #2



(No Subject)

From: +13367343824@tmomail.net

To: blessedalmsinc@bellsouth.net

Date: Wednesday, June 17, 2020, 12:14 PM EDT

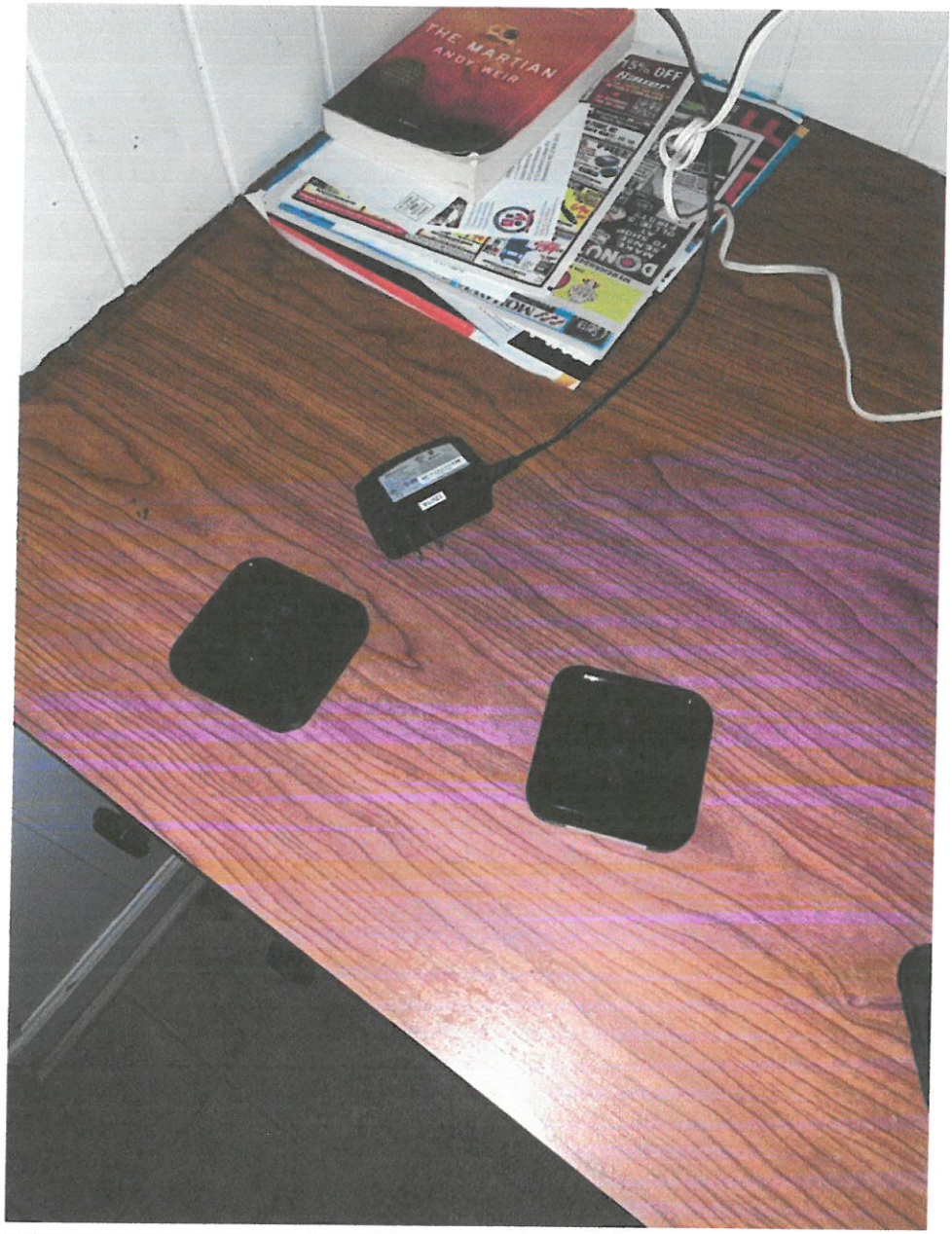
CLIENT #1 STANDING AT DOOR;
SHE WAS NEVER HURT!!!

T··Mobile··

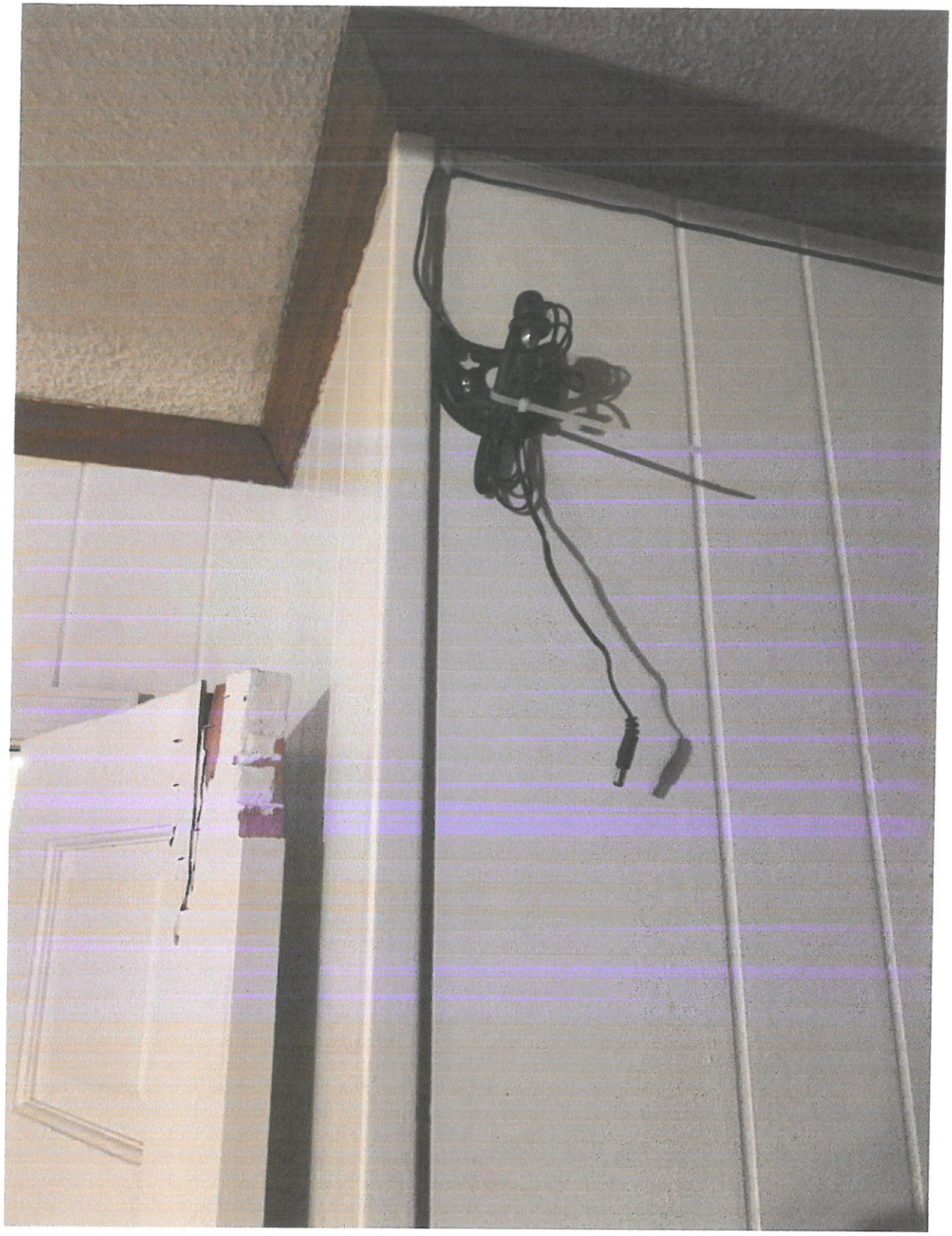
This message was sent to you by a T-Mobile wireless phone.

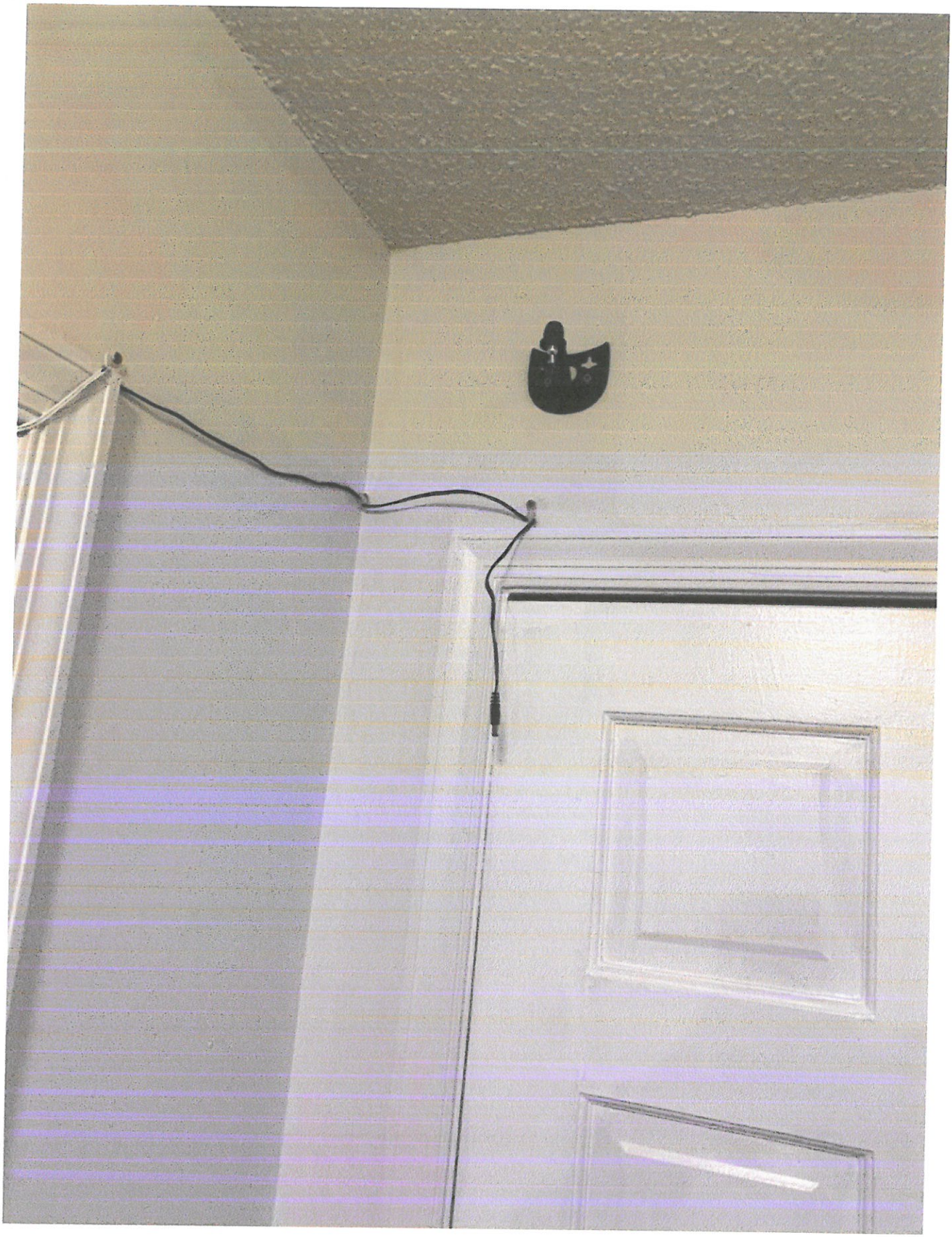
(No Subject)

From: +13367343824@tmomail.net
To: blessedalmsinc@bellsouth.net
Date: Wednesday, June 17, 2020, 1:58 PM EDT



THE REASON FC #2 COULD LIE ABOUT STANDING OUTSIDE ROOM WHERE FC #3 TRIPPED OVER HER FEET AND FELL. ALL THE CAMERAS WERE JERKED FROM THE WALL AND DESTROYED. NO ONE PUSHED FC #3





T··Mobile··

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