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	MHL092-935	A. BUILDING: _____ B. WING _____	C 11/18/2020

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RUSMED III	5401 ORCHARD POND DRIVE RALEIGH, NC 27616

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V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on 11/18/20. The complaint was unsubstantiated (Intake #NC00170130). A deficiency was cited. This facility is licensed for the following service category: 5600C Supervised Living for Adults with Developmental Disability.	V 000	Due to the recent incidents, Staff 4 and 6 have been placed in a refresher course by QP/CEO on professionalism. QP has researched on a 15 point training tool for staffing a health care organization. It is evident that staff 4 and 6 are not aware nor have they been informed or educated on professionalism. QP will supervise and go over each point. QP, Residential CC, and Residential Supervisor will each do	1/2/2
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy L Meadows TITLE: CEO, QP (X6) DATE: 12/10/20

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V 110	Continued From page 1 This Rule is not met as evidenced by: Based on interviews and record reviews, two of two current staff and one of one former staff (FS) (#4, #6 and FS #1) failed to demonstrate knowledge, skills and abilities required by population served. The findings are: Review on 11/5/20 of staff #4's personnel record revealed: -Date of Hire- May 2020 as Direct Care Staff Review on 11/5/20 of staff #6's personnel record revealed: -Date of Hire- July 2020 as Direct Care Staff Review on 11/5/20 of FS #1's personnel record revealed: -Date of Hire - August 2020 as Direct Care Staff -Departure date mid September 2020 Further record review on 11/16/20 of staff #4's record revealed: -On September 21, 2020, he received a monthly supervision via telephone concerning the event that took place at the group home on 9/19/20 -On October 13, 2020, he received in-service training in the areas of Professionalism, Work Place Safety and Team Building -October 13, 2020, he signed a corrective action form for lack of professionalism and failure to provide a positive work environment Further record review on 11/16/20 of staff #6's	V 110	Weekly Supervisions on Staff 4 and 6 for 90 days This training went in effect 11/20/2020 to ensure their level of competence.	

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V 110	Continued From page 2 record revealed: -On September 21, 2020 she received a monthly supervision consultation via telephone in reference to the incident that occurred at the facility on 9/19/20 and how the situation was a danger to the consumers -On September 25, 2020, she received in-service training certificates for Work Place Safety, Team Building and Professionalism -On October 13, 2020, she signed a corrective action form to provide a positive environment, attend all scheduled meetings and resolve personal issues outside of work environment Interview on 11/2/20 with staff #7 reported: -911 was called to the facility mid September 2020 but not for the clients -There was an altercation at the facility between two staff members (staff #4 & staff #6) During interview on 11/2/20 House Manager #1 stated: -There was an incident on 9/19/20 between staff #4 and #6. -Staff #6 brought the police with her to the group home that evening. -Staff #6 and staff #4 shared a rental car for two weeks because they did not have their own transportation. -The evening of 9/19/20 they were together in the rental car. -Staff #4 was stopping by the facility to "check on things." -FS #1 was working that night 11:00 PM - 7:00 AM. -Not sure why staff #4 went by the facility to "check on things," -No one from management had instructed him to do so that night and he did not inform management or FS #1 he was going by the	V 110		

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V 110	Continued From page 3 facility while not working. -Management had never instructed staff #4 to go by and check on the facility while not on the clock. -Staff #4 went by the facility at 9:00 PM and FS #1 let him in. -House Manager #1 received a text from staff #6 at 10:57 PM saying she was going to be late for her 11:00 PM shift (at sister facility) because there was stuff going on with staff #4 and the rental car. - She was working at the sister facility at the time, so House Manager #2 relieved her and headed to the facility to check on the situation. -Staff #6 called her back and said they were at the facility and she was there with police. -Staff #6 usually worked at the sister facility. -When she arrived to the facility everything was over, police didn't take a report. -Allegedly staff #4 put his hands on staff #6. -All of this confrontation occurred in the street in front of the facility. -No clients ever woke up during the incident and no one came into the home. -After staff #6 left, staff #4 had to call a ride service to take him home. -After the incident, she planned a meeting at the office to meet with staff #4 and #6 to discuss with management. -Staff #6 met with them first. -Had meetings scheduled with staff #4, but he canceled, then rescheduled and canceled again. -Eventually met with staff #4 to discuss his role in the incident. -At that point felt like there was more to it than what they were told. -Staff #4 was suspended for 1 month and staff #6 had a three-day suspension. -Prior to bringing them back to work, talked to them together and explained the rules. -Wanted to make sure they would be ok with	V 110		

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V 110	Continued From page 4	V 110		

passing each other during shift changes.
-Still not sure what they were doing at the facility that night.
-Staff #6 just said he was "checking on things."
-She, House Manager #2 and the Licensee always did pop ups at all times of night prior to this incident.
-FS #1 no longer worked at the facility, when they investigated the incident on 9/19/20, she quit.
-FS #1 had only been working 2-3 weeks before the incident on 9/19/20

Review on 11/3/20 of the police report revealed:
-911 responded to facility on 9/19/20 at 10:37 PM.

Interview on 11/3/20 with city police officer who provided police report stated:
-The call came from staff #6 stating there was a dispute between she and staff #4 over a rental car.
-Staff #6 stated she and staff #4 took the rental car together to go out of state for a few days.
-Staff #6 stated since returning staff #4 wanted more from the relationship than she did.
-Staff #6 stated her boyfriend found out about the trip and wanted to fight staff #4.

Interview on 11/4/20 with city police officer who responded to incident on 9/19/20 reported:
-Staff #4 and staff #6 had rented a car together to go out of state
-They rented the car to share for two weeks since they did not have their own forms of transportation
-On the evening of 9/19/20, staff #4 and staff #6 drove to the facility
-Staff #4 and staff #6 were arguing on the way
-Staff #4 put his finger in staff #6's face while in the car
-Once at the facility, staff #6 wanted the keys to

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V 110	Continued From page 5 the car -Staff #4 went in the facility with the keys to the rental car -Staff #6 called 911 -Staff #6 called her boyfriend to come to the facility -Boyfriend and staff #4 had a verbal altercation in the front yard -If Officers hadn't arrived, there would have been a physical altercation -Boyfriend didn't know the extent of staff #4 and staff #6's relationship -Boyfriend had found out about staff #4 and staff #6's trip out of town together -Boyfriend left the premise stating "this is who you want to sleep with", "I'm out of here" -There was a staff working in the facility but she did not get involved -Staff #4 stated that the car shouldn't go with staff #6 -Staff #4 paid for the rental car but the rental car agreement was in staff #6's name -Staff #4 felt they should have equal rights to the rental car -All of staff #4's belongings were in the car -Staff #6 was "taunting" staff #4 by yelling out "that's why you're homeless and living with your sister" -Staff #4 was allowed to get his stuff out of the rental car -The Officer went into the facility with staff #4 to make copies of the rental car agreement -Advised staff #6 that she could file charges downtown at the courthouse -Did not have enough evidence of any wrong doing and rental car was in staff #6's name -Staff #6 left with the rental car -Only staff #4 and FS #1 were at the facility when police left	V 110		

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V 110	Continued From page 6 Interview on 11/5/20 with FS#1 reported: -Worked 3-11PM and filled-in on 11-7PM at times -Felt that the Licensee and House Manager #2 were more upset with her leaving to get her food than the actual incident between staff #4 and #6. -On September 18th or 19th, 2020 there was an incident that happened on the facility property but not in the facility -Staff #4 knocked on the door around 10:30PM -Staff #4 said that he was going to take staff #6 to sister facility and would be back but FS #1 was not sure what he meant by that since she was already working -Staff #4 was not scheduled to work until 7:00am the next morning but told FS #1 that he wanted to be sure he was able to relieve her -Staff #4 had never done that before but has arrived 30 - 60 minutes early to relieve her in the past -Staff #4 and staff #6 never left the driveway -FS #1 did not see staff #6's face because she stayed by the car -Staff #4 started banging on the door asking FS #1 to come outside to be a witness because staff #6 called the police -Staff #4 told FS #1 that staff #6 was yelling that he hit her and that he would not give her the keys -Staff #4 came into the facility to get away from staff #6's boyfriend -Staff #6's boyfriend was ringing the doorbell and banging on the door -FS#1 continued talking to the boyfriend through the door saying that this was a facility with clients so he needed to stop banging on the door -Staff #4 told FS #1 to call the police and she said no for him to call -Staff #4 called the police, Licensee and House Manager #2 from inside the facility -FS#1 did not hear the conversation that occurred when staff #4 called 911, the Licensee and House	V 110		

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V 110	Continued From page 7 Manager #2 because staff #4 walked in another room -FS #1 was still talking to staff #6's boyfriend through the door -Staff #6's boyfriend was saying that staff #4 needed to come outside since he was putting his hands on his girlfriend -FS#1 heard boyfriend yelling at staff #6 saying, "this is who you want to sleep with?" -City Police arrived around 11:00PM -Clients were in their beds asleep -Staff #4 went out to speak with police and staff #6's boyfriend tried to chase staff #4 -Police stopped him and made him leave the premises -Around 11:30PM, client #1 woke up and asked what was going on because the police were there -Client #1 was re-directed to go back to bed -FS#1 ordered take-out food and mistakenly had it delivered to her home which is around the corner 5 minutes away -Staff #4 remained at the facility talking to the police -House Manager #2 arrived at the facility and called FS#1 to return back to the facility -Police were at the facility when FS#1 left to get her food and when she returned -Staff #4 left the facility around midnight -Licensee and House Manager #1 called FS#1 Monday morning to ask what happened -Licensee accused FS#1 of being "naive" -Did not like the way the Licensee or House Manager #2 spoke to her Interview on 11/13/20 with staff #6 reported: -Rented a vehicle with staff #4 on Sept. 14, 2020 -Neither of them had a car and staff #4 wanted to see his family out of town -Staff #4 needed someone to drive -Staff #6 and #4 spent 3 days out of town (Sept.	V 110		

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V 110	Continued From page 8 15th-Sept. 17th) -Was renting and sharing the car for two weeks to get around and get to work -Staff #4 had the car during the day of Sept. 19, 2020 while staff #6 was home sleeping -Staff #6 had to work that night at the sister facility. -Staff #4 called staff #6 around 9:00PM and said that he would pick her up for work -Staff #4 said that he would go to work and ask FS#1 to leave and he would work since he didn't have anywhere to sleep that night -Staff #4 told staff #6 that he didn't want to sleep in the car at the sister facility while staff #6 was working -Staff #6 stated that staff #4 was not in a good mood and "driving erratically" when he picked her up from her home -Staff #6 stated that she put her earphones in but he continued driving erratically -Staff #6 asked staff #4 if he wanted her to drive -Staff #4 started cursing at her and pulled over -Staff #4 put his hands in her face while continuing to curse and fuss at her -Staff #4 pulled off and headed to the facility because staff #6 said that she wasn't going to argue with him -Around 10:00PM, they arrived at the facility and staff #4 started getting his charger and things together to get out of the car -Staff #4 had all of his belongings in the car because he stays with his sister and didn't want to stay there anymore -Staff #6 told staff #4 to get all of his belongings out of the car because she didn't want to share the car anymore because he had a "nasty attitude" -Staff #4 "mushed" staff #6's head towards the window before going in the facility -Staff #4 took the keys to the rental car in the	V 110		

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V 110	Continued From page 9 facility with him -Staff #6 called the police because staff #4 had the keys and she could not leave -Staff #6 called her boyfriend who lived around the corner to inform him of what happened -Staff #6's boyfriend arrived before the police -He parked on the opposite side of the street and approached staff #6 at the rental car -He asked staff #6 where staff #4 was located -Staff #6 told him that staff #4 was in the facility and he asked her to go and get him -Staff #6 went to the door and rung the doorbell -Staff #6 could hear staff #4 talking behind the door but he never opened the door -Staff #6 continued ringing the doorbell -Staff #4 opened the door and staff #6's boyfriend yelled from the rental car "hand over the keys" -Staff #4 closed the door -Staff #6 called House Manager #1 around 10:30PM to tell her what was going on -Police arrived shortly after staff #6 called House Manager #1 -Staff #4 opened the door and said something but staff #6 was not sure what he said -Staff #6's boyfriend said to staff #4 "but you never came out and now you want to say something when the police is here" -Boyfriend left and the police told staff #4 to give staff #6 the keys because the car was in her name -Staff #4 asked how would he get his money back if he gave her the keys -Officer said that was between staff #4 & staff #6 but the car was in staff #6's name -Staff #4 said that he knows where staff #6 lived -Staff #6 said that staff #4 better not go to her house -Officers told staff #6 that she could go to the detention center to file charges because they didn't have enough evidence to charge anyone at	V 110		

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V 110	Continued From page 10 this time. -FS #1 left the facility and staff #4 was going to stay and work when staff #6 left -Staff #6 had planned to go and file charges at the detention center -House Manager #1 had told staff #6 to meet her at the grocery store down the street because she didn't want her driving to the detention center upset -House Manager #1 arrived at the grocery store and staff #6 told her that she was okay to drive -House Manager #1 told staff #6 that she would follow her to the detention center -House Manager #1 followed her majority of the way then turned off -Staff #6 stated that she tried to file charges against staff #4 but didn't have enough evidence -Staff #6 went to work at the sister facility where House Manager #1 was filling in until she arrived -House Manager #1 told staff #6 that staff #4 was sent home and FS #1 was called back to work -A meeting was held on Sept. 21, 2020 via telephone with Licensee and House Manager #1 -This meeting was supposed to be in person but staff #4 canceled saying that he was on the phone with an attorney to get his rental car money back and could not come in -Licensee told staff #6 that she was upset with her for not letting anyone know this is what she was going to do (rent a car with staff #4) -Staff #6 told Licensee that she did not need to tell her business to anyone -Sept. 21, 2020 staff #6 received a text message from House Manager #1 that stated that she was not going to be suspended but was going to be written up -Sept. 21, 2020, staff #4 was supposed to work 3-11PM at sister facility but House Manager #1 covered that shift and was relieved by staff #6 due to staff #4 being suspended	V 110		

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V 110	Continued From page 11 -Oct. 5th or 6th, staff #6 met with Licensee and House Manager #1 and was told that they wanted to bring staff #4 back to work but wanted to make sure that they were okay with each other -Staff #4 was supposed to be suspended for a month but came back to work after two weeks -Cross-trained to work Sister Facility -Staff #4 & staff #6 have crossed paths working in the facility and there had not been any issues Attempted interviews with staff #4 on 11/13/20 at 9:13AM and 11/17/20 at 9:39AM. Voicemail messages were left with no return call. Interview on 11/16/20 with Licensee reported: -No incident between staff #4 & staff #6 on Sept. 19, 2020 happened on the property of the facility or inside -Staff #4 & staff #6 were not at work -No clients were awake -No one in the facility called the police -Believed that staff #6 needed a ride to work -Doesn't know their personal business but heard that staff #4 & staff #6 rented a car together -Heard that staff #4, staff #6 and staff #6's boyfriend were arguing -House Manager #1 went to pick up staff #6 to take her to sister facility -Staff #4 was not given permission to go to the facility and tell FS #1 to leave -Very upset that this happened in the neighborhood -"We as black people should not be bringing this drama to the neighborhood or the group home" -Staff #4 was suspended for 2 or 3 weeks -Staff #6 was indirectly suspended since she was already off for a couple of days -Staff #4 and staff #6 were both written up. They both went in to the office to sign their write ups. -There was no harm to the clients	V 110		

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V 110	Continued From page 12 -Staff #4, #6 and FS #1 were all very good workers -Staff #4 is cross-trained to work Sister Facility -Doesn't know why FS #1 never came back to work Review on 11/16/20 of "Summary of Administrative Actions" completed by Licensee revealed: "On September 20, 2020, two of our staff were not working at either one of our facilities at the particular time of their disagreement. However, it was reported to us. While NO members were involved and it was after 10:00pm and ALL members were asleep; we wanted this duly noted as proper professionalism should be used at all times. This is not an act of hurt, harm or management, but a lack of sound judgement of the individuals involved. All persons involved have been offered an opportunity to share their version of their misunderstanding and express concerns. No charges were filed and no police report. This is an offense of public embarrassment. Due to racial tension in the Unites States, and all parties involved were Black, to involve the police could have been extremely detrimental. CEO (Chief Executieve Officer) advised ALL involved to cease any activities together on a personal level, as well as, communicate effectively and NOT near our facility. This occurred outside of our facility on the street approximately 600 feet from G3 (Group Home 3). This is still too close to our property. Administrative staff has been advised to offer training to ALL involved." Review on 11/18/20 of Plan of Protection completed by the Licensee on 11/18/20 revealed: -What immediate action will the facility take to ensure the safety of the consumers in your care? "Staff has been trained-retrained to ensure to act	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-935	A. BUILDING: _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSMED III	5401 ORCHARD POND DRIVE RALEIGH, NC 27616

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V 110	Continued From page 13 in a professionalism at all times. Team building is essential. Admin team expressed the importance of work place safety." -Describe your plans to make sure the above happens: "CEO (Chief Executive Officer), QHM & Administration have put all the of these steps in place. 1) Weekly supervisions via call. 2) Weekly pop up visits by CEO , QP (Qualified Professional) will be logged. 3) Quality performance evaluations. 4) Consulting with all involved as needed." Staff #4 and Staff #6 rented a car together for two weeks and took a trip out of state for a few days. Upon their return, they continued to share the rental car as they did not have their own form of transportation. Staff #4 and staff #6 were together on 9/19/20 when they stopped by the facilty approximately 10:00 PM. On the way to the facility they began to argue about who would retain the car that evening. Once they arrived at the facility, staff #4 jumped out of the car with the keys and ran inside the facility. Staff #6 attempted to knock on the door to get him to come out and when he did not she called 911 to report that he assaulted her while in the car. Staff #6 also contacted her boyfriend who arrived at the facilty and began knocking on the facility door cursing and yelling for staff #4 to come out. The police arrived and investigated the situation at which time staff #4 had then come out of the facility and was in the yard about to engage in a physical altercation with staff #6's boyfriend. The police went into the facility with staff #4 to make copies of the car rental agreement while all clients continued to sleep. After the incident was cleared up, staff #6 was able to leave with the rental car and staff #4 remained at the home with	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 110	Continued From page 14 FS #1 who was working. FS #1 then left staff #4 at the facility while she ran to her house to pick food up she had ordered that was inadvertently delivered to her home. Staff #4 was not scheduled to work that evening but had planned to stay the night as his living arrangements were unstable. House Manager #2 responded to the facility and instructed FS #1 to return to her shift and staff #4 to leave the facility. Staff #6 was written up and continued to work at the sister facility and staff #4 was suspended for two weeks, written up and now continued to work in the facility. Staff #4 and staff #6 failed to demonstrate competency by bringing their personal conflict to the facility on their day off. FS #1 failed to demonstrate competency by leaving staff #4 at the facility with the clients following the altercation between staff #4 and staff #6. All of these actions were detrimental to the health, safety and wellbeing of the clients and constitutes a Type B violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

December 7, 2020

Tammy R. Meadows, CEO
Russell Meadows Institute
308 W. Millbrook Rd., Ste. C
Raleigh, NC 27609

Re: Complaint and Follow-Up Survey completed November 18, 2020
Rusmed III, 5401 Orchard Pond Drive, Raleigh, NC 27616
MHL # 092-935
E-mail Address: rusmed6@gmail.com
Intake #NC00170130

Dear Ms. Meadows:

Thank you for the cooperation and courtesy extended during the complaint and follow-up survey completed November 18, 2020. The complaint was unsubstantiated.

As a result of the follow- up survey, it was determined that all the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. An additional deficiency was cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type B rule violation is cited for 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals - Tag V110.

Time Frame for Compliance

- Type B violation must be corrected within 45 days from the exit date of the survey, which is 01/02/21. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed deficiency by the 45th day from the date of the survey may result in the assessment of an administrative penalty of $200.00 (Two Hundred) against Russell Meadows Institute for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski,Team Leader, at 919-552-6847.

Sincerely,

Kimberly Thigpen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Tinika Ferguson, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant