Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL086034	A. BUILDING: ______ B. WING ______	C 05/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE LILY #1	103 PEACE LILY LANE DOBSON, NC 27017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 5/13/22. The complaints were substantiated (intake # NC00188468 and intake #NC00188617). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Clients from the sister facility will be identified using the letter of the facility and a numerical identifier. The staff listed in the report work at the facility and sister facility A and hold the same job titles. This facility is licensed for the same service category. Each facility is licensed for 9 beds and currently has a census of 7. The survey sample consisted of audits of 3 current clients for the facility and 4 current clients for the sister facility A.	V 000		
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,	V 110		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

This Rule is not met as evidenced by:
Based on record review, interview and observation, the facility failed to ensure 2 of 4 audited staff (the House Manager and staff #1) demonstrated the knowledge, skills and abilities required by the population served. The findings are:

Finding #1:
Cross Reference: 10A NCAC 27E .0101 Least Restrictive Intervention (V513) Based on record review and interview, the facility failed to provide services/supports that promote a respectful environment using the most appropriate settings and methods for 7 of 7 audited clients (#1, #2 #3) and clients (#A4, #A5, #A6 and #A7).

Finding #2:

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Review on 5/9/22 of client #3's record revealed:
- Documentation which indicated client #3 saw a physician on 4/28/22 and an "Unna" (an "Unna" is a compression bandage that is applied by a health care provider to treat slow healing leg wounds and ulcers) was put in place and she was to return to the physician in one week
- Documentation which indicated client #3 saw a physician on 5/5/22 and "Unna Boot" to remain in place. Client #3 was to return to the physician in one week
- Documentation completed by the Qualified Professional/Registered Nurse (QP/RN) on 5/8/22 "...[Client #3] has a wound on her R (Right) foot. The MD (Medical Doctor) has placed an unaboot. This bandage is NOT to be removed by staff..."

Observation on 4/29/22 at 1:25 pm of client #3's right foot revealed:
- A pink elastic bandage wrapped around the middle of her foot

Review on 4/29/22 of a photograph of client #3's foot sent via an email by Day Support Program (DSP) staff #1 (no date listed as to when the photo was taken) revealed:
- Client #3's left foot appeared to have skin peeling or skin that had peeled away from the top of her big toe and two of the toes to the left of her big toe
- An area of skin on the top of her left foot that appeared to have been skin that had peeled from the area
- No open or healing wounds were observed on her left foot
- Client #3's right foot had an area of what appeared to be peeling skin on top and underneath of her big toe and the three middle

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toes to the right of her big toe
- A scabbed over area underneath the three middle toes on her right foot
- A small scabbed over area on the top of her right foot and another small area with the beginnings of a scab on the far-right side of her right foot

Interviews on 4/29/22 and on 5/3/22 with client #3 revealed:
- She had participated in a car wash on 4/10/22 as part of a fundraising effort on behalf of the facility
- The House Manager had organized the car wash on behalf of the clients who resided at the facility and sister facility A, with clients from each facility having participated in the event
- The car wash began in the morning (no approximate time provided) and lasted until 6 pm
- The weather on the day of the car wash was sunny but windy
- Client #3 does not recall if she used any sunscreen prior to or during the car wash
- Her role during the car wash was to hold a sign which promoted the car wash
- She was wearing flip flops on the day of the car wash and she noticed the same day that her foot had become sunburned
- She informed the House Manager that she felt some discomfort on her foot and when a blister developed on her foot, she showed it to the House Manager (could not provide the date)
- She reported the House Manager "popped" the blister on her foot by putting a needle through it; however, he did not put any type of antiseptic cream on her foot afterwards
- The House Manager did follow up with her about her foot during the following days; however, he did not take her to see a doctor
- On 4/25/22, she had an appointment with

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her "psychiatrist" and during the visit, her "psychiatrist" asked how she was doing
- She reported to her "psychiatrist" that she had acquired a sunburn on her foot during the car wash held on 4/10/22
- She believed her "psychiatrist" called the House Manager and requested the House Manager take her to a doctor to have her foot examined
- She went to a "foot doctor" on 4/28/22 and the doctor put some type of dressing on her foot and wrapped it with a bandage
- She was concerned that no one took her to the doctor when she first developed the sunburn and injury to her foot because she was a "borderline diabetic."
- She stated the injury to her foot had been painful

Review on 5/3/22 of a "Patient Encounter Summary" from client #3's PMHNP-BC (Psychiatric Mental Health Nurse Practioner - Board Certified) and dated 4/25/22 revealed:
- " ...Overall, she feels she is doing well but has a significant sunburn on her right foot. She got the sunburn during a car wash fundraiser the group home had last week. It sounds as if the sunburn is a second degree burn. According to both pt (patient) and [House Manager], the burn is now scabbing over. There are no s/s (signs/symptoms) of infection, (no drainage, swelling, foul smell, etc.) [The House Manager] has been cleaning and monitoring the burn everyday. Given her history of cardiovascular issues and diabetes, it would be beneficial for her PCP (Primary Care Physician) to address the burn ..."

Interview on 5/3/22 with client #A6 revealed:
- He had participated in the car wash held

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on 4/10/22
- During the car wash, the clients had different jobs and client #3's job was to hold a sign promoting the car wash
- "Her foot got severely burnt."
- "I observed this myself."
- "It looked pretty bad."
- He could see her foot was "swelling up and looked infected."
- He was concerned about what he observed; however, he was not sure if client #3 spoke to the House Manager about her foot
- He believed that the Administrator in Charge (AIC) eventually took client #3 to the doctor
- He believed client #3 should have been seen by a doctor as soon as possible because he knew that client #3 had "partial diabetes."
- Sunscreen was available for the clients' use; however, he could not recall if he used sunscreen prior to going to the car wash or during the car wash that day

Interview on 5/10/22 with the House Manager revealed:
- The clients put sunscreen on prior to leaving for the car wash and staff brought sunscreen with them
- When asked if client #3 had developed a sunburn after the car wash held on 4/10/22, he stated client #3 got a "little bit of a burn on her foot."
- He does remember her foot being red; however, he does not recall her having a blister or her foot or any other injuries
- He believed any injuries she had sustained to her foot happened after he last worked on 4/26/22
- He does not report that he provided any first aid for any injuries to client #3's foot

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Interview on 5/3/22 with the Day Support Program (DSP) staff #1 revealed:
- He noticed all the clients "were red" when they arrived at the day program on 4/11/22; however, he did not notice client #3's foot until 4/15/22
- On 4/25/22, he spoke with client #3's medical provider at the behavioral health center where client #3 received services
- He reported his concerns regarding client #3's sunburn to her foot to the medical provider
- He telephoned the AIC on 4/27/22 to report his concerns regarding client #3's foot
- It was his understanding client #3 saw a physician on 4/28/22

Interview on 5/3/22 with DSP staff #2 revealed:
- On 4/11/22, she observed client #3's foot to be red, swollen and "it looked bad."
- She told the DSP #1 and he called the facility
- She was not sure who DSP #1 spoke to; however, "Nothing happened."
- Client #3 later told her that she had a "second degree" sunburn on her foot

Interview on 5/12/22 with the facility's QP/RN revealed:
- The clients at the facility use sunscreen prior to engaging in any outdoor activities
- She has seen the clients "slathered" down with sunscreen prior to and during outdoor activities; however, she could not speak definitively about the clients' use of sunscreen prior to or during this specific event
- While she did not know when the injury to client #3's foot occurred, she saw client on 4/14/22 and client #3 "never said a word and she had on shoes."

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- Client #3 was not a good historian of events
- Treatment of a sunburn would include submerging it in cold water as soon as you see the burn and contacting a physician especially, if you see a burn that has "bubbled up."
- When asked if client #3's diagnosis of diabetes would impact how quickly medical care should be obtained on her behalf, the QP/RN stated, "Absolutely."

Interview on 5/13/22 with the AIC revealed:
- The House Manager informed her that some of the clients had experienced some sunburn on the day of the car wash
- The clients always have sunscreen available for their use prior to and during their participation in any outdoor activities
- Sunscreen had even been prescribed by the clients' physicians and kept with their medications for their use
- She was not aware of there ever being a blister on client #3's foot and the House Manager having popped it
- She observed client #3's foot peeling the week before 4/26/22; however, client #3 wore flip flops that irritated places on her foot
- The DSP staff #1 called her on 4/27/22 and reported he felt the House Manager had "neglected" client #3 and she needed to go to the doctor immediately
- She was able to get client #3 in to see a podiatrist on 4/28/22 and she has had some follow up visits since the visit on 4/28/22
- On 4/28/22, the podiatrist placed an Unna boot on client #3's foot; however, client #3 removed it and refused to wear it as it was intended and would not wear shoes that did not irritate the places on her foot

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- She believed the facility sought care on behalf of client #3 in a responsible and timely manner; however, client #3 failed to follow the podiatrist's directives which led to it taking longer for her foot to heal

Review on 5/13/22 of the facility's Plan of Protection completed and dated 5/13/22 by the Administrator in Charge revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care?
Staff member is no longer employed by Peace Lily #1. Current staff informed they should inform administration and resident responsible person or guardian of resident health care concern within 24 hours, unless emergency or crisis situation."
- "Describe your plans to make sure the above happens: Administration will schedule training with the QP, RN for staff. Implementation of attached staff shift report. Staff should briefly document concerns about resident(s) observed and turn into House Manager or Administration. House Manager should review and document actions taken, if any, then give a copy to Administration for review and follow up."

This facility is licensed to provide supervised living services for adults with developmental disabilities. The clients' diagnoses included Bipolar Disorder (D/O); Traumatic Brain Injury; Autism Spectrum D/O; Psychotic D/O; Schizoaffective D/O; Mild Cognitive Impairment; Diabetes Type II; Unspecified Personality D/O; Borderline Intellectual Function; Major Depressive D/O and Obesity. The House Manager and staff #1 had the clients from this facility and sister facility A submit to an assessment of their cleanliness by having the clients come one by

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V 110	Continued From page 9 one into the staff office, pull down their pants and show their buttocks to the House Manager and staff #1 for inspection. The clients that were overweight were asked to pull their buttocks apart for a more thorough inspection. The House Manager took a photograph of the buttocks of a client from the sister facility A using a mobile messaging application (used to share photos, videos, texts and drawings) on his personal cell phone. The House Manager took the photograph as a means of showing the client he had not cleaned himself properly. As a result of these inspections, some of the clients reported they felt embarrassed, humiliated and ashamed. Also, the House Manager did not seek medical care for a client who acquired a sunburn on her foot after she participated in a fundraiser (a car wash) held on behalf of the facility. The client who is a diabetic reported she developed a blister on her foot and the House Manager used a needle to drain it but failed to put any antiseptic cream on the area where the blister had been. A total of 17 days elapsed between the time the client developed the sunburn before the facility sought medical treatment on her behalf. Based on the above information, the facility failed to deliver services that ensured the client's right to dignity and respect and failed to ensure medical care was obtained on behalf of a client in a timely manner. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3000.00 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 110		

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V 513 27E .0101 Client Rights - Least Restictive Alternative V 513

10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE
(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:
(1) using the least restrictive and most appropriate settings and methods;
(2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;
(3) providing choices of activities meaningful to the clients served/supported; and
(4) sharing of control over decisions with the client/legally responsible person and staff.
(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:
(1) using the intervention as a last resort; and
(2) employing the intervention by people trained in its use.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide services/supports that promote a respectful environment using the most appropriate settings and methods that did not create a loss of dignity and respect for 7 of 7 audited clients (#1, #2 #3 and clients #A4, #A5, #A6 and #A7). The findings are:

Review on 5/9/22 of client #1's record revealed:

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- An admission date of 3/16/21
- Diagnoses of Bipolar Disorder (D/O); Traumatic Brain Injury; Ataxia; Seasonal Allergies and Gastroesophageal Reflux Disease

Interview on 4/29/22 with client #1 revealed:
- "[The House Manager] made us all (clients from the facility and sister facility A) come into the office (at the facility) and pull down our pants and show him our butt cracks."
- It happened on two occasions; however, some of the clients only participated once
- "First time, we all had to do it, the second time, some of us didn't."
- The incidents happened in April 2022; however, client #1 could not provide the exact dates
- Staff #1 was present in the office on each occasion and she would either be on her phone or watched as the clients pulled down their pants
- While she was in the office, she never observed staff #1 intervene or say anything to the House Manager
- The House Manager never explained to the clients why he was having them come into the office
- She had "no idea why he did this to us."
- "All of a sudden he wanted to do this."
- She did not tell anyone, including her guardian what happened
- Having to pull down her pants "made her feel uncomfortable."

Review on 5/9/22 of client #2's record revealed:
- An admission date of 8/16/21
- Diagnoses of Bipolar D/O; Autism Spectrum D/O; PCOS (Polycystic Ovary Syndrome); Psychotic D/O; Severe Obesity; Thrombocytosis and Iron Deficiency

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Interview on 4/29/22 with client #2 revealed:
- The House Manager asked the clients to pull down their pants twice; however, she refused to do it a second time
- She did not recall the exact dates of when this occurred; however, it happened during the month of April 2022
- The House Manager was "checking our hygiene."
- She stated she was "tired of talking about this."
- "It gets old and today is a good day."

Review on 5/9/22 of client #3's record revealed:
- An admission date of 1/27/21
- Diagnoses of Schizoaffective D/O; Mild Cognitive Impairment; Diabetes Type II and History of Pulmonary and A fib (Atrial Fibrillation)

Interview on 4/29/22 with client #3 revealed:
- The clients (from the facility and sister facility A) were taken into the office and "we had to pull our butt cheeks open to see if we were clean."
- This happened twice; however, client #3 could not provide the exact dates of when the incidents occurred but reported it was three or four months ago
- The House Manager and staff #1 were present in the office each time when the clients were brought in
- The House Manager stated it was "because he wanted to make sure we were keeping clean."
- It was "kinda embarrassing."
- Some of the clients stated, "They felt violated, I felt violated."

Review on 5/9/22 of client #A4's record revealed:
- An admission date of 3/31/21

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- Diagnoses of Autism; Attention Deficit D/O and Attention Deficit Hyperactivity D/O

Interview on 4/29/22 with client #A4 revealed:
- The House Manager "was the one who wanted to see my butt to see if it was clean."
- The House Manager "does it because he thinks we don't clean ourselves."
- It had happened twice although, he could not recall the dates of when it happened
- "It made me look bad."

Review on 5/11/22 of client #A5's record revealed:
- An admission date of 6/1/15
- Diagnoses of Mild Mental Retardation; Anxiety; Bipolar; Depression; Diabetes Mellitus; Hypertension; Hypothyroidism and Hyperlipidemia

Interview on 4/29/22 with client #A5 revealed:
- "Sometimes people poop in their pants and [the House Manager] wanted to check my pants to see if they were dirty."
- It happened one time. "At first, it didn't bother me, but later on I felt violated."
- He believed the incident happened in March of 2022
- Staff #1 was in the office with the House Manager; however, he never heard staff #1 say anything to the House Manager about what the House Manager had the clients to do

Review on 5/9/22 of client #A6's record revealed:
- An admission date of 4/4/19
- Diagnoses of Unspecified Personality D/O; Borderline Intellectual Function and Self-Esteem; Major Depressive D/O, Recurrent Episode, Moderate

Interview on 5/3/22 with client #A6 revealed:

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- The House Manager asked the clients from the facility and sister facility A to come into the staff office to be "checked."
- The House Manager wanted to check each client to see if they had any fecal matter on their person or on their clothing
- The clients from each facility were checked on two occasions in April 2022
- Each time it occurred, it happened in the staff office at the facility
- There was no announcement as to what was going to happen prior to the clients being called to the office
- The House Manager and staff #1 were present in the office
- When client #A6 went into the office, "They observed buttocks for any fecal matter and if so, you would be asked to go take a shower."
- It was "kinda embarrassing and humiliating."
- Neither the House Manager nor staff #1 touched him; however, he was asked to "pull open my butt cheeks."
- He participated in being checked because he was asked to; however, he felt he was "coerced" into doing so
- "It felt invasive."
- "It didn't bother me as badly, but with some of the others, it's been more traumatizing."
- A more appropriate way to do this would have been to ask the clients to check themselves and if they felt they needed to take a shower, then they could
- He never heard staff #1 question the House Manager or ask him to stop what he was doing
- "He (the House Manager) had complete control over what happened in the group homes."

Review on 5/9/22 of client #A7's record revealed:

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- An admission date of 2/26/20
- Diagnoses of Mild Mental Retardation and Obesity

Interview on 5/9/22 with client #A7 revealed:
- He did not like having to pull his pants down
- He pulled them "all the way down."
- The House Manager took a photo of his buttocks and showed it to him
- He was not sure why the House Manager took the photo or if it had been deleted
- Client #A7 could not provide the date of when the incident occurred

Review on 5/6/22 of staff #1's record revealed:
- A hire date of 11/30/21 as a House Parent

Interview on 5/6/22 with staff #1 revealed:
- She was surprised this situation had come up because the events happened "at least a month ago."
- The clients from the facility and sister facility A had gathered at the facility when she started noticing a "pretty strong feces, body odor, mostly feces smell."
- When the clients from each facility arrive home for their day program, they will come to the facility to have a snack or participate in an activity together and then they separate
- She and the House Manager tried to check where the odor was coming from by just walking around the clients; however, they couldn't determine where the odor was coming from
- They had the clients remain in the living room and then called them each into the office
- The clients were told there was an odor in the facility, and they were trying to determine where it was coming from
- The clients pulled down their pants in the

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back only with the front of their bodies remaining covered
- The House Manager asked the clients to bend over to be checked
- The clients that were "heavier, were asked to pull apart their butt cheeks to see if they were clean."
- If they were clean, they were sent out of the office
- If they were not clean, they were spoken to about wiping properly and instructed to take a shower
- The clients that never had a problem with their personal hygiene were not checked
- Client #2 agreed to be checked once; however, she reported that she did not want to be checked a second time because it had made her uncomfortable
- Staff #1 reported she had been told by the House Manager "hygiene checks" were a part of their job responsibilities
- Although she was not currently trained in providing personal care services, she was scheduled to participate in personal care services training in the coming weeks

Review on 5/6/22 of staff #2's record revealed:
- A hire date of 12/1/21 as a House Parent

Interview on 5/6/22 with staff #2 revealed:
- She had not participated in checking any of the clients for cleanliness; however, she had learned about the checks from the House Manager and staff #1
- She understood the checks happened about a month ago when the House Manager and staff #1 smelled an odor in the facility when the clients from the facility and sister facility A had gathered
- When the House Manager or staff #1

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could not determine where the odor was coming from, the clients from the facility and sister facility A were brought into the office one by one
- The House Manager informed the clients he was going to perform a "hygiene check."
- The clients had to "pull down their pants and bend over a little bit."
- She was not sure if "they had to part their butt cracks;" however, she felt "it may have been necessary because some of the residents are larger."
- The clients who had fecal matter on their person were instructed to take a shower
- "Over half of them had fecal matter on them."
- After the clients who needed to take a shower were finished, the House Manager requested to check them a second time
- Client #2 stated that she did not wish to be checked a second time and she was not required to be checked
- Neither the House Manager nor staff #1 touched any of the clients per their report to her
- She had no concerns about the House Manager
- "[The House Manager] is absolutely amazing, cares about the residents."

Review on 5/6/22 of the House Manager's record revealed:
- A hire date of 1/20/21 as House Manager
- A job description signed by the House Manager and dated 1/20/21
- The job description listed one of the House Manager's "major responsibilities" to " ...Help maintain the self-respect, personal dignity and physical safety of each resident ..."

Interview on 5/10/22 with the House Manager revealed:

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V 513	Continued From page 18 - He called the clients one by one into the office and told them what he had to do - The clients were from the facility and the sister facility A - "I didn't touch anyone." - "If the client was dirty, I just told them how to clean up." - Staff #1 was also present in the office and participated in checking the clients for cleanliness - This had happened in late March 2022; however, "No one said anything until a month and a half after." - The clients did not pull their pants down all the way, "just so their back end showed." - "They bent over just a little bit." - They did not check all the clients and when client #2 refused to be checked a second time, she was not required to - Most of the clients have issues with incontinence and receive care with bathing as well as tying their shoes and putting their clothing on - He was "genuinely confused" as to what he had done wrong - Providing personal care services was part of his job responsibilities and he had completed a class to become a personal care aide when he was employed by an assisted living/nursing facility owned and operated by the same owner of the facility and sister facility A - "I'm a personal care aide. I don't understand why this is a thing." - "I get in trouble for the silliest things." - "If there was something that could have been done differently, I wanna know about ...I felt like I was doing my job and I get caught up on silly things." - He felt he checked the clients in the most private way possible as the facility bathrooms did not have locks on the doors, and someone may	V 513		

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V 513	Continued From page 19 have walked in on them during the check - "The office is the only locked spot." - "They had absolute privacy and it was the most respectful way to do it." - When asked if he had taken a photo of client #A4's buttocks, he replied, "No, I did not, I showed him "like a reflection image, not a photo." Review on 5/6/22 of the Qualified Professional/Registered Nurse's (QP/RN's) record revealed: - A hire date of 6/9/21 as the QP Interview on 5/12/22 with the QP/RN revealed: - On 5/8/22, she spoke with the clients at the facility and sister facility A - Prior to this meeting, none of the clients had reported they had to submit to a check for cleanliness - Some of the clients were more talkative than others and others had to be prompted to discuss what had happened - Client #A4 reported the clients had to go to the police department because the House Manager "looked at our butt." - Client #2 reported the checks had happened on at least two occasions; however, she refused to participate a second time and stated, "I felt violated." - All the clients denied being touched by the House Manager and staff #1 - None of the clients could provide an exact date of when the incidents occurred - Staff #1 was in the office with the House Manager during the "incontinence checks"; although she had not yet received training in how to provide personal care services - She was surprised everyone was checked as some of the clients don't require personal care services	V 513		

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- None of the clients reported to her that they had to pull down their pants completely or spread their buttocks apart
- One of her concerns was that everyone knew what was happening and they all started talking about it among themselves
- "The clients did not like it; it could have been done on their bath day."
- Although the House Manager had been trained to provide personal care services, he had been trained when he was an employee of the assisted living facility owned by the same person who owned the facility and sister facility A
- While some of the clients in the group home required personal care services, how personal care services were delivered should be based on the population you're serving
- It was important to keep fecal matter off the buttocks of clients; however, "different settings require different actions."
- In the group home setting, the clients are "younger and more body conscious."
- It was "paramount to respect the dignity of those who are developmentally delayed, or they will get their feelings hurt."
- "In my professional opinion, the House Manager had the clients' best interests at heart."
- Prior to this situation, she had no concerns about the House Manager's treatment of the clients

Interview on 5/6/22 with the Administrator in Charge (AIC) revealed:
- The Police Chief called her at 4:15 pm on 4/26/22 and requested she come to the police department immediately
- The House Manager had just walked up to her and reported he was trying to locate some of the clients (from the facility and sister facility A) as they had not arrived home from their day

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program
- Shortly after that, the clients arrived at the facilities with some of them being noticeably upset
- The clients would not tell her where they had been nor would the day support staff who had transported them home from their day program
- Upon her arrival at the police department, the Chief informed her the clients had just left after meeting with him and other officers
- The Chief reported to her that the clients had reported to him and the other officers that the House Manager had the clients come into his office and told them to "Drop your pants, drop your drawers and let me inspect your anus."
- Per the Chief, this happened a month prior based on the clients' statements to them
- She was "in shock and disbelief" and reported to the Chief that none of the clients had reported this to her
- The clients from either facility could walk to her office at the building across the driveway from the facilities and talk to her or the Owner whenever they wished
- She attempted to explain to the Chief that some of the clients received personal care services and the House Manager had been trained to provide that type of care
- The Chief believed the House Manager still had no right to check the clients, even if he were certified
- She was still in the process of trying to determine what had happened and had spoken with client #A4 and other clients (not interviewed as part of this survey) and no one reported to her what the Chief alleged the clients had stated to his officers and him on 4/26/22
- Client #A4 only reported to her that he was upset because he thought the House

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Manager didn't believe him when he told him he had taken a shower
- Client #A4 reported that he pulled his shorts halfway down and showed his buttocks to the House Manager and staff #1
- Neither the House Manager nor staff #1 touched him
- Since 4/26/22, she continued to check in with the clients in the morning and the afternoon as she typically saw them when they left and returned home from their day programs
- She had also gone to each facility to check in with the clients
- The clients had been upset because staff from the day program had taken them to the police department without telling them why they were going
- She believed that someone from the day program and the police department should have called her or the clients' guardians before taking them to the police department and especially before the clients were interviewed by the police

She was concerned that continuing to interview the clients was creating a level of anxiety on their behalf; however, the facility's QP/RN would be speaking with them on 5/8/22
- She had spoken with the House Manager on 4/26/22 and he was emotional and stated to her that he felt there was a "target on his back" as this was the third allegation made against him by the staff at the day support program

Interview on 5/6/22 with the Owner revealed:
- On 4/29/22, she interviewed staff #1 and the House Manager
- Staff #1 reported that the clients from the facility and sister facility A had gathered one evening at the facility
- Sometimes the clients from the facility and the sister facility liked to eat together and

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socialize with each other
- Staff #1 reported there was an "overall odor" in the facility and the House Manager decided to have the clients participate in a "hygiene assessment."
- As the House Manager is a certified PCA (Personal Care Aide), he had each of the clients come into the office (one by one) with the door closed
- He told the clients he was going to do an assessment and asked the clients if this were okay
- The House Manager stood behind the client while staff #1 stood in front of the client
- He told the clients to pull down the back of their pants "a little bit."
- The House Manager had the clients pull down their pants far enough so he could check to see if any of the clients had any feces on them
- Some of the clients are "kinda heavy" so the House Manager had those clients use their hands to pull their butt cheeks apart so he could gain a better view/assessment of their cleanliness
- At no time did the House Manager or staff #1 touch the client
- Per staff #1, there was no frontal exposure of any of the clients at any time
- Staff #1 stated that if a client refused, they could leave the room
- Based on what was observed, several of the clients required instruction on how to properly clean themselves during bathing and toileting
- Those clients were spoken to and encouraged to take a shower
- She also interviewed the House Manager on 4/29/22 as well and he relayed the same information to her as staff #1 had
- There was an odor in the facility and when they could not pinpoint it to one resident, the House Manager performed "hygiene

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assessments" on the clients
- There was no touching and no photographs were taken of any clients
- She was comfortable with the House Manager being able to conduct the "hygiene assessments" as he had trained to provide personal care services
- She did not believe this had happened only once
- Staff #1 had not received training in personal care services and was only in the room as a witness
- Staff that were not trained to provide personal care services were not allowed to perform a "hygiene assessment."
- Training for staff #1 was scheduled to be held during May 2022
- She stated that previous House Managers had engaged in "hygiene assessments."
- "Hygiene assessments are typical in health care."
- None of the clients had ever reported anything negative about the House Manager, other than he is "very good to them, he helps them."
- "This is the first House Manager that I've not had any complaints on."
- She did not talk with staff #2 as she was not reported to have been present when the "hygiene assessments" were performed

Interview on 4/29/22 with the Day Support Program (DSP) staff #1 revealed:
- On 4/26/22, DSP staff #2 reported to him that she made an off-hand comment to client #1 about not getting any feces on the bathroom seat when she used the bathroom
- One of the other clients overheard the conversation between DSP staff #2 and client #1 and the client stated, "You don't have to worry

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about that, we've done been checked for it."
- When the DSP staff #2 inquired more about what the client meant, the client did not want to say anything else because she appeared embarrassed
- Client #2 then reported that all the clients at her facility had been "asked to line up outside of the office and brought into the office one by one and asked to pull their pants down; spread their butt cheeks and then checked for cleanliness."
- Client #A4 also overheard what was being said and stated, "I did too."(which meant he also went into the office for the inspection)
- Client #A4 reported the House Manager made the clients submit to the inspections
- The DSP staff #1 contacted his supervisor who asked him to speak to one more client to determine if he also reported what the others had said
- He spoke to client #A5 who initially denied anything that happened but then confirmed what clients (#1, #2, and #A4) reported
- He contacted his supervisor a second time and reported what client #A5 said
- His supervisor advised him to contact the police. An officer came to the day program and he reported the details of what he had learned to the officer
- The officer directed him to the police department in the city where the events allegedly occurred
- He transported the clients to that police department where the clients were interviewed by three officers including the Police Chief
- After the interviews were completed, he spoke to the Chief who reported that all the reports were "pretty much the same."
- He transported the clients to their facilities after the interviews were completed

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- Since the events of 4/26/22, client #A4's behaviors had been disruptive during the day program because the House Manager was no longer at the facility; while other clients had expressed concerned the House Manager would return to work at the facility

Interview on 5/3/22 with the Adult Protective Services Social Worker #1 (APS SW #1) revealed:
- She and two of her co-workers arrived at the facility on the evening of 4/26/22 and interviewed all the clients who resided in the facility as well as the clients who resided in sister facility A
- She and her co-workers divided up the interviews among the three of them with client #1 being one of the clients she interviewed
- Client #1 reported to her that she and the other clients had to go into the office on two occasions (dates unknown) one by one and pull their pants down and have their buttocks checked by the House Manager for cleanliness
- Client #1 reported the House Manager did not touch her during the inspection
- The APS SW #1 reported the House Manager was also interviewed by the APS staff on the evening of 4/26/22
- The House Manager reported that clients from the facility and sister facility A were at the facility watching a movie in the living room
- Staff #1 informed him there was an odor in the facility
- He and staff #1 tried to determine where the odor was coming from but when they could not determine the "culprit," the House Manager decided to line the clients up and bring them into the office one at a time
- The House Manager reported to the APS staff that as he did not want to single any one

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	MHL086034	A. BUILDING: ______ B. WING ______	C 05/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE LILY #1	103 PEACE LILY LANE DOBSON, NC 27017

(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
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client out, he had all the clients participate in a "hygiene check."
- He reported he had each of the clients come into the office and pull down their pants and pull their butt cheeks apart so he could see if they were clean
- He reported that he did not touch the clients during the "hygiene check."
- If the client was found to be clean, they could leave the office and return to the living room
- If the client was not clean, he spoke to them about how to clean themselves better and to go take a shower
- He reported client #2 stated to him that the process "made her feel uncomfortable" after she was checked
- He explained to her that he didn't want to single anyone out, so everyone had to be checked
- He reported client #2 appeared to understand at that time
- Although the House Manager had not reported to the APS SWs that he had taken a photo of client #A4's buttocks, he did report to the police that he had taken a photo of client A4's buttocks using the "Snapchat app (application)" on his personal cell phone
- He reported to the police that he took the photo because client #A4 did not believe he was not clean, and he wanted to be able to show him
- He reported he used the "Snapchat app" because the photo deletes itself and there is no record of the photo having been taken
- The House Manager reported the "hygiene checks" had occurred once in April 2022 and once three to four months prior
- Because the House Manager had been trained in how to provide personal care services, he believed it was okay for him to conduct the

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"hygiene checks" and reported that former House Managers had done the same thing in the past
- He did not report these events to the Administrator in Charge (AIC) because he did not feel he needed to as it was part of his job responsibilities
- During her client interviews, none of them reported this had happened before
- When she spoke with staff #1, she confirmed what the House Manager had reported; however, she asked the House Manager if it was okay for them to check the clients in the manner he had chosen
- Staff #1 reported the House Manager told her it was okay as they had been trained to provide personal care services
- As part of her investigation, she had spoken with the facility's QP/RN who trained the House Manager in how to provide personal care services
- Staff (#1 and #2) were not a part of this training class
- The QP/RN reported to her that the way the House Manager checked the clients was not something she would have taught him to do
- The QP/RN reported to APS SW #1 that she would have told the students in her class that if they smelled an odor and could not determine its origin, to "meander around and sniff it out."
- If they were able to determine who might have an odor, they should be discreet and request the person accompany them to the bathroom so they could address the issue with the person privately
- When asked if she would have the clients line up and come into an office individually for a "hygiene check," she stated, "Absolutely not."

Interview on 5/11/22 with APS SW #2 revealed:
- On 4/26/22, she and APS SW #1 and

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their supervisor went to the facility to interview the clients from the facility and sister facility A
- She interviewed clients (#1 and #3) and client #A4 separately
- Since 4/26/22, she had also met with her supervisor and APS SW #1 to discuss their findings
- The clients she interviewed confirmed the House Manager had each of them come into the office to be checked for cleanliness
- The clients she interviewed reported they were lined up outside the office and taken into the office one by one to be checked for cleanliness and it had happened in April 2022
- The clients reported they pulled their pants "all the way down" and "[The House Manager] looked to see if they were dirty."
- It was also reported to her that some of the clients had to "spread their butt cheeks."
- APS SW #3 also came to the facility to interview his ward (client #A7) only
- Client #A7 reported to APS SW #3 that the House Manager had taken a photo of #A7's buttocks on his personal cell phone
- During staff #1's interview, she confirmed the House Manager did take a photo of client #A7's buttocks
- None of the other clients reported they had their photo taken while in the office
- When the House Manager was interviewed, he reported he believed he could check the clients in the manner he did because he had been trained to provide personal care services
- "He assumed because he was the Manager, it was okay."
- The House Manager reported it was the "way he had been trained."
- None of the clients she interviewed believed they had a choice about being examined

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- All clients believed they were in trouble or they had gotten someone else in trouble
- "They didn't know it was wrong and they could say no."
- "They didn't know they could talk to anyone about it."
- She believed it was "poor judgement" on the House Manager's part to conduct the inspections

Interview on 5/11/22 with APS SW #3 revealed:
- He was the legal guardian representative for client #A7
- He met with client #A7 the evening of 4/26/22 and client #A7 was the only client he interviewed
- Client #A7 reported to him the House Manager had him "drop his drawers" and "pull his butt cheeks apart" so the House Manager could determine if he had "soiled himself."
- Client #A7 had a history of not being able to keep himself clean and this may have been one of the reasons, the House Manager "targeted" client #A7 to be checked
- Client #A7 reported there was a female staff in the room and "[The House Manager] made [staff #1] do it (observe the clients being checked for cleanliness), she didn't want to do it."
- Client #A7 reported the House Manager took a photo of client #A7's "rear end" to show client #A7 that he wasn't clean
- He had been told by his coworkers the House Manager reported to the police investigating the incident(s) he used the "Snapchat app" on his phone to take the photo because the photo deletes itself afterwards
- He was concerned that "although the photo was deleted, that somewhere that photo still exists."
- Prior to this incident, he had never had a

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V 513	Continued From page 31 problem with the House Manager - "[The House Manager] was trying hard but went out of bounds ..." - "It was not smart on his part." - He was concerned that the House Manager "took advantage" of people who did not know what he did was not okay - "It was important that clients be treated with dignity and respect." This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 513		