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PRINTED: 06/08/2022
FORM APPROVED

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
	MHL023002	A. BUILDING: _____ B. WING _____	C 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND VOCATIONAL INDUSTRIES, INC.	650 NORTH POST ROAD SHELBY, NC 28150

(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 5/26/22. The complaint was substantiated (intake # NC00188666). A deficiency was cited. This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities and 10A NCAC 27G .5500 Sheltered Workshops for Individuals of All Disability Groups. The survey sample consisted of audits of 1 current client. The current census was 74.	V 000		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete Health Care Personnel Registry (HCPR) checks prior to hire for 2 of 2 audited staff (Custodial Staff and Staff #2). The findings are: Review on 5/17/22 of the Custodial Staff	V 131	Healthcare Registry review on all non-direct care staff, including alleged staff, was completed by [redacted] on 5/25/2022 and no incidents or reports were found. Direct Care staff documentation was also reviewed by [redacted] on 5/25/2022 to ensure a Healthcare Registry review has been completed within last 12 months. Healthcare Registry review was added to New Hire checklist in new HRIS system for all new hires by [redacted] Temporary Staffing Service was notified by [redacted] on 5/19/2022 that a Healthcare Registry review will need to be run on all positions for Cleveland Vocational Industries, Inc.	5/25/2022

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Drew — TITLE: HR Director — (X6) DATE: 6/17/2022

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V 131	Continued From page 1 employee record revealed: -Hired 12/23/13. -No HCPR was found. Review on 5/18/22 of Staff #2's employee file revealed: -Multiple hire date - last one being 2/21/22 - paraprofessional. -HCPR check completed 2/22/22. Interviews on 5/17/22 and 5/18/22 with the Qualified Professional/Program Director (QP/PD) revealed: -She was responsible to complete HCPR checks and thought they only needed to be done for direct care staff. Interviews on 5/17/22 and 5/25/22 with the Human Resources Director revealed: -The QP/PD was responsible to conduct the HCPR checks. -She thought they only needed to be done for direct care staff as well. -She would ensure the checks would be completed on all staff and prior to hire.	V 131		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective	V 366	The following language has been updated/added to our current Policy of Abuse and Policy of Incident by [redacted] 1) All allegations of suspected abuse, neglect, and/or exploitation will be reported to DSS and Law Enforcement, regardless of guardian directive 2) All allegations of suspected abuse, neglect, and/or exploitation will be reported to the LME within 5 days.	6/17/2022

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V 366	Continued From page 2 measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or	V 366		

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V 366	Continued From page 3 with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;	V 366		

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V 366	Continued From page 4 (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the local Department of Social Services (DSS) and local Law Enforcement of a level III sexual abuse allegation for 1 of 1 client (Client #1). The facility also failed to provide written preliminary findings to the Local Management Entity (LME) within five working days of the incident. The findings are: Review on 5/17/22 of Client #1's record revealed: -Admitted 8/29/08. -Age 27. -Diagnoses of Moderate Intellectual Developmental Disability (IDD) and other specified Attention-Deficit Hyperactivity Disorder (ADHD). Review on 5/17/22 of the Custodial Staff employee record revealed: -Hired 12/23/13. Review on 5/17/22 of a North Carolina Incident Response Improvement System (IRIS) report for Client #1 revealed: -Date of incident - 4/26/22; level III -Sexual Abuse/Assault/Rape was checked - "(Client #1) reported that a custodial staff person entered the bathroom stall with him and that they	V 366		

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V 366	Continued From page 5 touched each others penis." -Incident Prevention - "(Custodial Staff) has been suspended pending further investigation." -The authorities and others contacted section was blank for County DSS and Law Enforcement Agency. -An incident comment by a local agency on 4/28/22 noted to make a report to DSS, upload the internal investigation and complete the alleged staff members information under the HCPR section. -Other Information: "...Guardian did not feel that a DSS report was necessary at this time." -The report was last updated/re-submitted by the facility on 4/29/22. Interviews on 5/17/22 and 5/18/22 with the Qualified Professional/Program Director (QP/PD) revealed: -She was responsible to complete the IRIS reports. -She was not notified when other reviewing agencies made comments on the report, but could see them when she accessed the report. -She did not make a report to DSS as she asked the guardian if she wanted DSS to be called and the guardian said no. -She was not aware she needed to notify DSS and Law Enforcement. -She was not aware she needed to upload the preliminary findings of the internal investigation with 5 business days.	V 366		
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	V 512		

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V 512	Continued From page 6 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 observation, interview and record review 1 of 2 staff audited (Custodial Staff) sexually abused 1 of 1 audited client (Client #1). The findings are: Review on 5/17/22 of the Custodial Staff employee record revealed: -Hired 12/23/13. Review on 5/17/22 of Client #1's record revealed: -Admitted 8/29/08. -Age 27. -Diagnoses of Moderate Intellectual Developmental Disability (IDD) and other specified Attention-Deficit Hyperactivity Disorder (ADHD).	V 512	1. Client #1 was instructed to utlize the single person lobby restroom on 4/26/2022 by [redacted] and continues to do so 2. Alledged staff was escorted from the premises by [redacted] hortly after the allegation on the morning of 4/26/2022 and has not returned. Staff employment has been terminated. 3. Continue project to install video monitors throughout the common areas of the facility. In case of a future similar allegation, it would assist in establishing timelines of entering the private, non-monitored areas. Video monitoring systems quotes had been previously received and we are reviewing financing options and then will determine a project time line. Projected for 3rd Quarter 2022. [redacted] responsbile for approving finances for project. [redacted] will manage the project once approved. 4. Training for recognizing signs of abuse and neglect will be provided on June 22, 2022 by the McLaughlin Young Group for all CVII staff, regardless of position. [redacted] coordinating the training	4/26/2022 4/26/2022 Estimated for Q3 2022 Planned for 6/22/2022

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V 512	Continued From page 7 -4/14/22- Treatment Plan - Goal: "...tends to leave his staff without warning, does not return to his designated area...will return to assigned tasks after breaks/lunch within 5 minutes..." Review on 5/17/22 of a North Carolina Incident Response Improvement System (IRIS) report for Client #1 revealed: -Date of incident - 4/26/22; level III -Sexual Abuse/Assault/Rape was checked - "[Client #1] reported that a custodial staff person entered the bathroom stall with him and that they touched each others penis." -Incident Prevention - "[Custodial Staff] has been suspended pending further investigation." Interview and Observation at 2:10 p.m. on 5/17/22 with Client #1 revealed: -He was in the bathroom and the Custodial Staff came into his stall. -This happened "a few weeks ago." -Custodial Staff asked him to touch him and he did. -Custodial Staff touched him as well. -He pointed to his private area when asked where he and Custodial Staff touched each other. -Then the Custodial Supervisor came into the bathroom. -He asked several times throughout the interview if he was in trouble and if he was going to jail. A second interview on 5/18/22 with Client #1 revealed: -During the incident a few weeks ago, he was on the commode with his pants down and Custodial Staff was in the stall too with his pants down. -Custodial Staff was facing the stall door and he put "my thing in his butt." -Then the Custodial Supervisor came into the bathroom.	V 512		

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V 512	Continued From page 8 -This had happened a "whole bunch of times." -He asked again if he was in trouble and if he was going to jail. -Client asked if he could show surveyor the bathroom. Observation and interview on 5/18/22 at 1:30 p.m. of the men's bathroom with Client #1 revealed: -There were 3 stalls with doors on them. -Client #1 pointed to the 3rd stall and said that was where it happened. -As he sat on the commode he said this was where he was when the Custodial Staff walked in to his stall. Review on 5/17/22 of statements taken by the Qualified Professional/Program Director (QP/PD) during the facility's internal investigation revealed: -Client #1 was interviewed on 4/26/22 and 4/27/22 about what happened in the men's bathroom. -4/26/22 - Client #1 asked if he was in trouble and if he was going to jail. -Client #1 said the Custodial staff came into his stall and touched him and he touched the Custodial Staff. -When asked where they touched he said "their private parts." -4/27/22 - Client #1 asked if they were going to call his mom. -Client #1 said the Custodial staff came into his stall and sat on his lap and then got up. -Client #1 did not mention touching each other until specifically asked. -4/26/22 - the Production Supervisor stated upon entering the men's restroom he witnessed the Custodial Staff coming out of the 3rd stall. -His buttocks were exposed and he was pulling up his pants as he walked toward him.	V 512		

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V 512	Continued From page 9 -He immediately noticed there was someone else in the stall where the Custodial Staff had just exited. -He walked out of the restroom with the Custodial Staff and when he went to re-enter there was a female staff person standing outside the restroom looking for Client #1. -He entered the men's restroom and Client #1 was there, he notified Client #1 staff was looking for him. -He then went to the QP/PD to report what he witnessed. -4/28/22 - Custodial Staff - started his statement with "Approximately a year ago, one morning as I was starting to clean the men's restroom I opened the door...and [Client #1] was laying in the floor and appeared to be simulating having sex on the floor. He jumped up and begged me to not tell anyone. Which I agreed to...I asked [Client #1] to let me know if he felt the need to lay in the floor again and I would mop/clean the floor. I feel like I possibly got too relaxed with [Client #1]. I had even stood at the door at his request before while he was in the restroom. [Client #1] had started confiding in me and telling me things like he couldn't have a girlfriend, he couldn't have sex, etc. I felt that he needed me to be a friend. Overtime, I started walking outside during the lunch break and he started walking with me. At times other clients also go. While walking we would listen to rap music and it would be dirty rap with the music talking about sexual things and [Client #1] would make a comment that he could do that to me. One day he was helping me with the janitorial duties, [Client #1] told me that his girlfriend had come over on Sunday and that they had sex in his backyard. I asked him if his mom could see him and he said no. I then asked him what exactly he did and he replied that he stuck it in her hole...Tuesday (4/26)...I went to the	V 512		

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V 512	Continued From page 10 bathroom. As I was using the bathroom, [Client #1] came in the bathroom. I was in the third stall which is the stall that [Client #1] thinks he has to use. I had unlocked the door and [Client #1] came to the stall. I asked [Client #1] to wait a minute and let me get my pants up and get out of the way. [Client #1] asked me if the floor was clean and I told him that yes we had already mopped it. I was coming out of the stall door and [Client #1] was about to lay in the floor as the bathroom door opened. I told [Client #1] that it was [Production Supervisor]...." Interviews on 5/17/22 and 5/25/22 with the Production Supervisor revealed: -He supervised the Custodial Staff. -On 4/26/22 he was looking for Custodial Staff to give him his pay stub. -As he entered the men's bathroom he looked at the stalls and saw 2 sets of feet in the 3rd stall. -The 2 sets of feet were facing each other and the stall door was closed. -Before he could say anything the Custodial Staff "came flying out" of the stall. -He had windbreaker type of sweat pants on and he was trying to pull them up. -The front of his sweat pants were pulled up and he was holding on to them, his buttocks were completely exposed. -The Custodial Staff said "I told him (Client #1) not to come in there." He was using the toilet and told Client #1 not to come in there; he rushed in there and didn't give him a chance to get up. -He walked out of the bathroom with the Custodial Staff and discussed some pay check issues and then went back to see who else was in the bathroom. -He was gone approximately 3 minutes before returning to the men's bathroom. -When he arrived he saw Client #1's direct care	V 512		

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V 512	Continued From page 11 staff standing outside of the bathroom looking for him. -He looked in the bathroom and Client #1 was at the sink washing his hands. -He then went to look for the QP/PD to report what he witnessed. -Client #1 came to him as he searched for the QP/PD and asked was he in trouble and was he going to jail. Observation and interview on 5/25/22 at 11:25 a.m. of the men's restroom with the Production Supervisor revealed: -As the door opened it made a creaking sound. -He pointed to the 3rd stall and said this was where he saw two feet as he was coming around the corner into the bathroom. -The stall door opened inward toward the commode. -The opening to the stall was approximately 2 feet wide. -The latch to the door slides to lock and was functioning properly. -He sat on the commode and showed how as he closed the stall door it was approximately 2 inches from hitting his knees. -As surveyor walked in and attempted to close the stall door, it was necessary to have legs against the commode to get the stall door around the body to close it. -Surveyor stepped back to the corner of the entrance and it was possible to see the Production Supervisor's feet while in the stall. Interviews on 5/18/22 and 5/25/22 with Direct Care Staff #2 revealed: -She was assigned to the group Client #1 was in on 4/26/22. -She remembered Client #1 told her he had to use the bathroom.	V 512		

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V 512	Continued From page 12 -He was gone approximately 5-10 minutes and she went to look for him. -When she arrived to the men's restroom the Custodial Staff was standing just outside of it next to his cleaning cart. -He said "I was getting up off the toilet and he (Client #1) just barged in..." -Her first thought was how could he barge in if the stall door was latched. -Client #1 did not have a history of talking about sex or sexual matters. Interviews on 5/17/22 and 5/18/22 with the QP/PD revealed: -She had known Client #1 since 2008 when he started coming to the facility. -Client #1's inappropriate behavior included horse play, picking/teasing other people, cursing and talking about drinking. -She had not seen any sexualized behavior with him and nothing had been reported to her about sexualized behavior or comments. Interview on 5/18/22 with Client #1's legal guardian revealed: -When she received the call on 4/26/22 about the incident she immediately came to the facility to speak to Client #1. -He was still nervous when she arrived and wanted to make sure he was not going to get in trouble. -Client #1 told her he went to the bathroom and was sitting on the toilet and the Custodial Staff came in and sat on his lap. -Once she and Client #1 returned home he told her it wasn't the first time this happened. -When asked why Client #1 didn't tell anyone he said Custodial Staff told him not to tell anyone. -Client #1 was asked did you put your private parts in him, he said yes, did Custodial Staff put	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023002	A. BUILDING: _____ B. WING _____	C 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 512	Continued From page 13 his private parts in you, he said yes. -She asked him where and Client #1 said in his butt. -Client #1 did not have a history of sexualized behavior or sexualized talk. Interview on 5/18/22 with the Custodial Staff revealed: -He took walks with Client #1 at lunch time and sometimes another client would walk with them. -He did not inform staff of Client #1 talking about sexual matters with him; that was not part of his job. -Everyone should know he talked about these things - that was what Client #1 always did. -On 4/26/22 he went to the bathroom, he was in the 3rd stall, and someone came in behind him. -He stood up off the toilet and unlatched the door while still pulling up his pants. -Client #1 "pushed" his way into the stall and went to the back of the stall by the commode. -Both of them were in the stall at the same time. -When asked how long they were in the stall together - "Couldn't be no time...a second or so..." -He could not explain why he unlocked the stall door while his pants were still down. "I mean they weren't down around my ankles or nothing." -His Supervisor then came into the bathroom looking for him and he walked out with him due to concerns about his check. -He denied doing anything sexually inappropriate with Client #1. Review on 5/25/22 of the Plan of Protection dated 5/25/22 written by the Human Resources Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Associate (Client #1) will be instructed to utilize the single person restroom in the lobby. This	V 512		

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V 512	Continued From page 14 restroom remains locked and the key to open must be requested from the front desk receptionist 2. Alleged staff will be removed from the premises 3. Healthcare Registry review will be run on all non-Paraprofessional staff and all newly hired personnel going forward, regardless of position 4. Continue project to install video monitors throughout the common areas of the facility Describe your plans to make sure the above happens. 1. Associate (Client #1) was instructed to utilize the single person lobby restroom on 4/26/2022 and continues to do so 2. Alleged staff was escorted from the premises shortly after the allegation on the morning of 4/26/2022 and has not returned 3. a. Healthcare Registry review on all non-Paraprofessional staff has been completed as of 5/25/2022 and no incidents were found. Paraprofessional staff documentation was also reviewed on 5/25/2022 to ensure Healthcare Registry review has been completed within the last 12 months b. Healthcare Registry review will be added to New Hire checklist in new HRIS system for all new hires c. Temporary Staffing Service was notified on 5/19/2022 that a Healthcare Registry review will need to be run on all positions for Cleveland Vocational Industries, Inc. 4. Video monitoring system quotes had been previously received and we are reviewing financing options and then will determine a project time line" Review on 5/26/22 of an addendum to the Plan of Protection dated 5/26/22 written by the Human	V 512		

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V 512	Continued From page 15 Resources Director revealed the following was added: "What immediate action will the facility take to ensure the safety of the consumers in your care? 4...In case of a future similar allegation, it would assist in establishing timelines of entering the private, non-monitored areas... Describe your plans to make sure the above happens. 2...Staff employment will be terminated... 4. Projected for 3rd Quarter 2022." Client #1 was a 27-year old male who had diagnoses of Moderate IDD and other specified ADHD. He was not known to have a history of inappropriate sexualized behavior. Client #1 consistently reported to staff, to his guardian and to the surveyor of sexual encounters he had with the Custodial Staff. One being they touched each other in their private areas, the other being the Custodial Staff sat on his lap and they had intercourse. Both encounters happened in the stall of the men's bathroom. Custodial Staff acknowledged he engaged in conversations that were sexual, including asking probing questions about Client #1 and his girlfriend having sex, and listening to rap music with him with sexual content and the client mentioning what he could do to him sexually. The Custodial Staff never reported this to staff but admittedly continued to engage in these inappropriate sexual conversations with the client for approximately a year. The Custodial Staff acknowledged he opened the bathroom stall door, without being fully clothed, and Client #1 entered the stall. Custodial Staff acknowledged at one point they were both in the stall together and that Client #1 was closest to the commode. The Production Supervisor witnessed both sets of feet in the	V 512		

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V 512	Continued From page 16 same stall, their feet were facing each other and the stall door was closed. When the Custodial Staff heard someone coming into the restroom he rushed out of the stall with his pants covering the front part of his body, however his buttocks were completely exposed. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An Administrative penalty of $1,500 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		