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	MHL079-106	A. BUILDING: _____ B. WING _____	09/21/2022

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 9/21/22. The complaint was substantiated (intake #NC00192457). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for three and currently has a census of two. The survey sample consisted of audits of two current clients and one former client.	V 000		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for	V 512		

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V 512	Continued From page 1 dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview, 1 of 7 current staff (staff #1) abused 1 of 1 Former Client (FC #1). The findings are: Review on 9/15/22 of staff #1's record revealed: - A hire date of 8/21/17 - A job description which defined staff #1 as Support Staff - Paraprofessional Review on 9/13/22 of FC #1's record revealed: - An admission date of 7/5/22 - A discharge date of 9/7/22 - Diagnoses of Attention Deficit Hyperactivity Disorder (D/O), Combined Type; Post-Traumatic Stress D/O; Persistent Depressive D/O; Conduct D/O and Intellectual Developmental Disability, Mild - A Behavior Support Plan dated 12/8/21 which documented FC #1 had a history of behaviors which included but were not limited to the following: physical aggression, property destruction; elopement and verbal aggression which included the use of profanity, becoming loud and intrusive, making threats, and using racial slurs - A Psychological Evaluation dated 1/19/19 which documented FC #1 had a Full-Scale Intelligence Quotient of 64 Review on 9/14/22 of notes completed by the On Call social worker (OCSW) with a Department of Social Services (DSS) revealed: - On 8/24/22, an OCSW met FC #1 at a police department to investigate his allegation of having	V 512		

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been struck by staff #1 at his facility
- FC #1 reported to the OCSW he was lying down on the floor in his bedroom and began banging the back of his head on the floor. " ... [FC #1] states thereafter staff member [staff #1] 'busted' in his room and told him to 'get the f**k up.' [FC #1] stated that [staff #1] was upset with him earlier in the day after he [staff #1] had learned that he [FC #1] had called his brother [staff #2] (also a staff member at the group home) a N****r. [FC #1] states that while he [FC #1] was getting off the floor [staff #1] stated 'I'll show you what a N****r is and smacked [FC #1] across his right head close to his temple. *SW (OCSW) noticed a red mark on the side of [FC #1's] head ..."
- " ... [FC #1] states that he swung back at [staff #1] but missed. [FC #1] stated that [staff #1] continued to hit him on both sides of his head until he got back on the floor to cover himself with his arms. [FC #1] states that thereafter [staff #1] pulled him by his feet to an open area in the room and started to kick him on the side of his ribs. *SW (OCSW) observed a red mark on the side of [FC #1's] right rib but was unable to determine if it was caused by a kick ..."
- OCSW took photos of FC #1's head and his side to include in his investigative report
- FC #1 reported to the OCSW that he "managed to get to his feet and attempted to run out the front door. [FC #1] states he was stopped by [staff #1] on the porch where he [staff #1] grabbed him from the back and placed him in a hold. [FC #1] stated that he shifted his weight and he and [staff #1] both fell on the front lawn where they tumbled around wrestling. [FC #1] states that he managed to get on his feet again and run to the neighbor's home where 911 was called ..."

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V 512	Continued From page 3 - FC #1 reported that client #2 and another staff member (he could not identify) were present during the incident - The unidentified staff member yelled, "Y'all stop right now!!!" - Client #2 attempted to assist him during his altercation with staff #1 - FC #1 stated he and staff #1 had never been in a physical altercation before the one on 8/24/22 - "When asked if he had called the staff member (unidentified) a n****r, [FC #1] says 'I did call him and n****r I was talking to myself.'" - The OCSW visited the facility the evening of 8/24/22 and spoke with staff #1, client #2 and the Program Director (the PD) - Client #2 reported to the OCSW that he heard FC #1 and staff #1 "fighting" in FC #1's bedroom and he saw staff #1 hit FC #1 - Client #2 reported that FC #1 struck staff #1 first but was not completely sure because he did not see how the altercation began - He also reported he observed FC #1 run out of the front door of the facility with staff #1 "grabbing" FC #1 and both of them falling onto the front lawn and "wrestle for a while." - Client #2 did not see how the altercation ended as he was directed to go to his room - No indication in the report who directed client #2 to go to his room - Client #2 had witnessed FC #1 and staff #1 get into "verbal arguments" in the past; however, he had never seen the two of them engage in any type of physical altercation - Staff #1 reported to the OCSW that he went into FC #1's bedroom, he observed FC #1 banging the back of his head on the floor and as he attempted to assist FC #1 up from the floor, FC #1 "swung at him."	V 512		

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- " ... [Staff #1] admitted to reacting to the swing by striking [FC #1] back, but was not able to recall how or where he hit [FC #1] ..."
- Staff #1 reported that FC #1 ran out of the facility, and he stopped him by "grabbing him from behind and placing him in a hold on the front porch."
- Both FC #1 and staff #1 fell to the ground and he released FC #1 from the hold and FC #1 then ran to a neighbor's home
- " ...When asked if he was upset about [FC#1] calling his brother a N****r [staff #1] says 'no'. [Staff #1] stated that he was trying to keep [FC #1] from hurting himself ..."
- Staff #1 agreed to leave the facility until the DSS investigation was complete

Review on 9/14/22 of the photographs included in the OCSW's report revealed:
- A photograph of FC #1's face with red markings on the right temple
- A photograph of a faint mark on FC #1's stomach which began on the right side and stretched across his stomach
- Each photograph had FC #1's name and the name of the OCSW and 8/24/22 noted on the photograph

Interview on 9/14/22 with an Adult Protective Services Social Worker (APS SW) revealed:
- On 8/25/22, she had spoken with the police Detective assigned to investigate the 8/24/22 incident
- The Detective informed her that she had reviewed the police officer's body camera video and staff #1 had admitted to the officer on the video that he had struck FC #1 on 8/24/22
- The Detective stated she planned to interview staff #1 on 8/26/22 and agreed to allow

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V 512	Continued From page 5 the APS SW to sit in with her during the interview - She made an unannounced visit to the facility on 8/25/22 and met with the Program Director (PD), the Qualified Professional (QP), the Lead Staff (LS) and FC #1's Care Coordinator who were all present at the facility - The PD reported that on the evening of 8/24/22, staff #1 was the only staff present in the facility - She received a phone call from him and decided to come to the facility - The PD stated staff #1 reported to her that FC #1 was banging his head on the floor in his bedroom and when he went into FC #1's room, FC #1 hit staff #1 in the eye (breaking his glasses) and then ran out of the door of the facility - FC #1 ran to a neighbor's home and told the neighbors he was "being held hostage" at the facility and not allowed to use the telephone - The neighbors called the police on behalf of FC #1 and staff had also called the police once FC #1 ran from the facility - The PD reported staff #1 had been suspended while the incident was being investigated but had not been terminated from his position with the facility - She informed those present that staff #1 admitted to the police and the DSS OCSW he had struck FC #1 based on what was in the OCSW's report - All those in the room remained silent and no one offered any response to her statement - On 8/26/22, she met with a Detective with the police department and sat in on the interview between the Detective and staff #1 - During the interview, the Detective asked staff #1 what happened between him and FC #1 on 8/24/22	V 512		

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V 512	Continued From page 6 - Staff #1 reported he had heard banging coming from FC #1's bedroom and when he went into FC #1's room and asked him to get up from the floor, FC #1 "swung at him." - Staff #1 reported his glasses came off and FC #1 ran out of the facility - He reported he had attempted to keep FC #1 from going into the street, but he was able to get away from him and run to a neighbor's home - Staff #1 reported he could not fully remember what had happened between him and FC #1; however, he believed any injuries FC #1 may have sustained occurred when he banged his head on his bedroom floor or when he had attempted to restrain FC #1 while they were outside - He reported that while he was attempting to restrain FC #1, they had lost their balance and fell to the ground - The Detective informed staff #1 that FC #1 reported to police that staff #1 had struck him before they were outside in the yard - The Detective asked staff #1 why he admitted to a police officer and the OCSW that he had struck FC #1 - Staff #1 denied that he had admitted this to the police officer or the OCSW - The Detective again asked staff #1 to state what happened and staff #1 stated he didn't remember exactly what happened - The Detective spoke with her about what the charges could be for staff #1 and then went back into the interview and informed staff #1 he was being charged with "assault on a handicapped person." - She had since concluded her investigation which included an interview with FC #1 and others involved in his care and it was determined the allegation would be "confirmed" but	V 512		

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V 512	Continued From page 7 unsubstantiated - She stated this finding meant that there was sufficient evidence that abuse had occurred; however, FC #1 did not require "protection" as staff #1 was no longer in the facility and FC #1 had been discharged - She had sent the appropriate paperwork to the agency which oversaw the operation of the facility and had notified the QP of her department's findings Review on 9/14/22 of a "Reporting Officer Narrative" completed by a police officer and dated 8/24/22 revealed: - Officer reported he responded to the facility on 8/24/22 in reference to a report of a runaway from the facility - He spoke with staff #1 who reported he went into FC #1's bedroom because FC #1 was banging his head on the floor - Staff #1 reported to the officer " ...He stated he told [FC #1] to stop. Then [FC #1] acted like he could not get up, so at that time [staff #1] tried to help him up and [FC #1] threw a punch at him. At that time, [staff #1] reacted and he stated he struck him but don't remember where he struck him. He stated [FC #1] then went outside and tried to leave, they tried to stop him, they then began to roll around in the front yard, right before the officer pulled up [FC #1] took off ..." - The officer spoke with FC #1 who reported that he was banging his head on the floor in his bedroom when staff #1 came into his bedroom and said, "what's all that God d**n noise." - FC #1 reported that staff #1 cursed at him and told him to get up from the floor and " ...he did not get up fast enough and [staff #1] smacked him on the right side of the head. While [FC #1] was on the ground [staff #1]	V 512		

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started hitting him and kicked him. [FC #1] went outside and they began rolling in the dirt. [FC #1] stated [staff #1] was trying to put his face in the dirt. [FC #1] then got away and went up the street ..."
- The officer documented in the report the interviews were recorded on his body camera

Review on 9/14/22 of an "arrest report" completed by a police officer on 8/26/22 revealed:
- " ...The defendant (staff #1) named above unlawfully and willfully did assault and strike [FC #1], an individual with a disability by striking [FC #1] in his face while in the bedroom after picking him up from the floor. He further followed the victim out of the door wrestling him on the ground before releasing him ..."
- Staff #1 was given a secure bond of $5000.000 with a court date of 9/8/22

Interview on 9/14/22 with FC #1 revealed:
- On 8/24/22, he had been in the shower, talking to himself and singing a song with the "N word" (N****r) in it
- Staff #2 heard him using this word and came to the door and stated, "Hadn't me and my brother (staff #1) asked you not to use the 'N word?'"
- He apologized to staff and when he got out of the shower, he attempted to explain to staff #2 that he wasn't calling him the "N word."
- Staff #2 stated, "Yes, you did" and reported that he was going to call his brother (staff #1) and inform him of what FC #1 had said
- When staff #1 came into work, he "noticed something was bothering [staff #1]" and he believed it was because staff #2 had told him what he had been saying/singing while in the

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shower
- Stated staff #1 "had a mad look on his face," so he left him alone for about an "hour to hour and ten minutes."
- He went to his room but then came back out to the area where staff #1 was sitting and asked if he could watch television while staff #1 completed paperwork
- Staff #1 told him "No" and he responded by saying, "That ain't fair."
- "I guess I triggered him some way" because staff #1 "banged on the desk and said, "G*****n, you know what's not fair? Me coming to work and having to deal with you [FC #1]."
- Staff #1 stated he heard FC #1 had called his brother (staff #2) the "N word."
- Staff #1 stated, "Didn't I tell you not to use the 'N word?' I'm gonna show you what a 'N word' can do."
- He backed up because he didn't know what staff was going to do and then went into his bedroom
- He was sitting on the floor and then laid down flat on his back and "banged his head (the back of his head) twice on the floor."
- Staff #1 came into his room and "put his hands behind my head" in an attempt to keep him from continuing to bang his head on the floor
- Client #2 came into his bedroom and "was telling [staff #1] not to do something stupid."
- Staff #1 told him (FC #1) to "get yo b***h a*s up and stop crying."
- As he stood up, staff #1 hit him on the right side of his head and he fell between his bed and his dresser, "in the gap."
- Staff #1 "hit me three or four times."
- He covered his head with his hands as staff #1 struck him in the head
- He had "knots on the front, side, back and

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top" of his head
- Staff #1 never struck him in the face
- Client #2 saw staff #1 strike him at least one time
- "[Client #2] tried to get [staff #1] off me."
- He kicked staff #1 in the lip and noticed he was bleeding from either his gum or his tooth
- He "wasn't trying to kick him (staff #1) but trying to take my shoe to pry him off of me."
- He ran out of the facility and staff #1 followed him outside and "put me in a hold."
- He attempted to get out of the hold, by moving from side to side and he "spun around" which caused them to fall to the ground
- "I was rocking my body and spinning" in an attempt to break the restraint he was being held in
- He picked up a stick and threatened to throw sand in staff #1's face while they were on the ground but then stopped and told staff #1, "I don't wanna fight no more."
- He agreed to go inside the facility; however, as staff #1 sat on the front porch, "drinking water, and trying to catch his breath", he "bolted from the door" and ran from the facility to another house a "couple of blocks" from the facility
- He told the individuals at the house what happened, and they called the police on his behalf
- He spoke with police and an individual with DSS, and he was returned to the facility later that evening
- Staff #1 was not at the facility when he returned, and he did not see him again prior to his being discharged from the facility on 9/7/22
- He "missed" staff #1
- "He's (staff #1) a good person, real smart, educated, knowledgeable and loves his job."
- He wanted staff #1 to have "a second

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V 512	Continued From page 11 chance." Interview on 9/15/22 with client #2 revealed: - FC #1 and staff #1 were in FC #1's bedroom (could not provide the date) and he observed FC #1 hit staff #1 and "[staff #1] went off on him." - He observed staff #1 "hit [FC #1] to get [FC #1] off of him." - FC #1 hit staff #1 in the face and staff #1 struck FC #1 in the face - "[FC #1] was fighting [staff #1], so [staff #1] had to defend himself." - He tried to stop staff #1 from continuing to strike FC #1 and "pushed" staff #1 off of FC #1 - He told staff #1 to go into another room as FC #1 was continuing to try to hit staff #1 - Staff #1 had a "busted lip" and he believed this was from where FC #1 had hit him in the face - FC #1 ran outside and staff #1 had to "grab him and bring him back inside." - FC #1 came back inside and "five minutes later he ran off." - He did not see FC #1 until the following day and did not observe any marks or bruises on his face Interview on 9/16/22 with the Lead Staff (LS) revealed: - She was working at the facility on 8/24/22 with staff #1 in the kitchen and her sitting at the staff desk - She heard banging coming from one of the client bedrooms and staff #1 checked in FC #1's bedroom and observed him banging his head on the floor - Staff #1 told her what he had observed, and she directed him to encourage FC #1 to stop banging his head on the floor	V 512		

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V 512	Continued From page 12 - She didn't get up and go into the bedroom; but she could hear a "little scuffling going on." - She had remained at the desk to complete her notes and to ensure the other client in the facility was safe - She was still at the facility when FC #1 ran from the facility with staff #1 attempting to restrain him - She observed staff #1's shirt being ripped as he attempted to keep FC #1 from going into the street - She never observed staff #1 strike FC #1; however, she believed FC #1 had kicked staff #1 and there was a "little something going on with his eye." - She believed staff #1's glasses were also broken - FC #1 ran up the street and to a neighbor's house; however, the neighbor would not allow any staff to come onto their property - Client #2 was in his bedroom during the events of 8/24/22 - She saw FC #1 that same night and did not observe any marks or bruising on him - "It all happened so fast; I may be forgetting ..." Interview on 9/19/22 with staff #1 revealed: - On 8/24/22, he was the only staff present prior to the altercation between him and FC #1 - He knew FC #1 was upset because he had been redirected during the previous shift for this use of the word, "N****r." - He heard banging noises coming from FC #1's bedroom and when he went to check on FC #1, he observed him banging his head on the floor and crying - He asked him what was bothering him, and FC #1 reported that he was upset because he felt	V 512		

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	MHL079-106	A. BUILDING: _____ B. WING _____	09/21/2022

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V 512	Continued From page 13 he'd had more freedom at his previous provider's home which was an AFL (Alternative Family Living) facility - He bent down and attempted to help FC #1 get up from the floor and FC #1 "swung at him." - FC #1 knocked his glasses off of his face and because he couldn't see clearly, he called for client #2 to come to his aid - He was able to get away from FC #1 and went into the office area of the facility and called the LS and requested she return to the facility - FC #1 ran outside and he ran outside after him and when FC #1 threatened to run into the street, he attempted to restrain him; however, both fell to the ground - They were able to get up and as FC #1 held onto a "column" on the front porch, he held FC #1 by his arm; however, FC #1 was able to break free and "took off running." - He went inside and called the police to report FC #1 had left the facility - He did not recall striking FC #1 in the face; however, he did use his hand to "push him off of me." - He "jammed his thumb" (did not indicate which thumb) as a result of him having "pushed" FC #1 off of him - He "pushed" FC #1 on the side of his body or his chest - During the altercation with FC #1, his shirt was torn, his lip was bleeding, and his glasses were knocked off - His shoulder was also sore (due to an old rotator cuff injury) which was aggravated due to the events of 8/24/22 - If FC #1 had any injuries to his face, it may have been because his face came in contact with the concrete pathway in front of the facility when he and FC #1 were on the ground	V 512		

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V 512	Continued From page 14 - "It's all a blur." - Staff #2, the LS, and the PD arrived at the facility with staff #2 leaving to go look for FC #1 - Police arrived at the facility and also went looking for FC #1 - He spoke with the OCSW, and another staff was called in to relieve him of his duties that evening, and he had not returned to the facility since 8/24/22 - Since the events of 8/24/22, he had been arrested and charged with assault - He had an attorney and planned to address the charges in court - He had pressed charges against FC #1 but had been told by police that because FC #1 was considered to be incompetent, he would not be held responsible for his actions - He did not understand why FC #1 could not be found accountable for his behavior on 8/24/22 Interview on 9/15/22 with the PD revealed: - She received a telephone call from staff #1 at approximately 7 pm on 8/24/22 and determined she needed to come to the facility - When she arrived, she observed staff #1 sitting on the front porch of the facility and she could tell he was "beat up." - Staff #1's glasses were broken, his lip was "busted," his eye was swollen, and his shirt was torn - Staff #1 told her FC #1 was in his bedroom and banging his head on the floor and when he attempted to keep FC #1 from banging his head, FC #1 kicked him in the eye which caused his glasses to break - He "looked confused and said he didn't know if he hit him (FC #1) or not;" however, he never admitted to her that he'd struck FC #1 - A police officer spoke with staff #1 at the	V 512		

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V 512	Continued From page 15 facility; however, the police did not speak to any other staff - Staff #1 did not complete his shift on 8/24/22 as he had to leave the facility per the DSS OCSW's directive - FC #1 returned to the facility at approximately 11 pm on 8/24/22 - She did not observe FC #1 to have any injuries that night and she also saw him on the following day (8/25/22) and did not observe him to have any injuries - Believes the events of 8/24/22 were triggered by something that had happened the previous day when staff #2 spoke with FC #1 about his use of racial slurs - FC #1 was discharged from the facility on 9/7/22 - Staff #1 had not returned to work at the facility since 8/24/22 - Staff #1 had been a "faithful, dependable" staff Interview on 9/13/22 with the QP revealed: - On 8/24/22, the PD informed him of FC #1's allegation against staff #1 - He notified FC #1's on-call worker with the agency which provided guardianship services on his behalf - He also followed up with FC #1's guardian on the 8/25/22 via telephone and met with the APS social worker and the PD, the LS and FC #1's Care Coordinator at the facility on the same day - He had been responsible for completing the internal investigation of FC #1's allegation that staff #1 had struck him on 8/24/22 and submitting the required paperwork to the Healthcare Personnel Registry (HCPR) - His interview with staff #1 revealed that staff #1 had gone into FC #1's bedroom to address	V 512		

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V 512	Continued From page 16 some noise coming from the room when FC #1 struck him and then ran from the facility - FC #1 admitted to him that he had kicked staff #1 and broke his glasses and then ran to a neighbor's home and reported he was being held hostage at the facility - Staff #1 was the only staff present at the facility during the alleged incident - Based on the initial information, he was able to gather and FC #1's history of violence and lying on staff and others, he could not determine if staff #1 had struck FC #1 - When he spoke with FC #1, he did not observe any injuries to his person while at the facility or at his day program on 8/25/22 - As a result of his investigation, it was determined to be inconclusive that staff #1 had struck FC #1 - He knew that staff #1 had been arrested and charged with "assault on an incompetent person" and staff #1 had pressed charges of assault against FC #1 - Staff #1 had been suspended on 8/24/22 and had not returned to work - FC #1 had been discharged to another facility on 9/7/22 - He had been informed that DSS did not substantiate the allegation of abuse and he was awaiting the letter of notification - He had also received notification from personnel with HCPR, they would not be initiating an investigation Interview on 9/20/22 with the Manager of agency which owned the facility revealed: - He was not aware of the information the surveyor used to substantiate the allegation against staff #1; especially that staff #1 had admitted to having pushed FC #1 off of him	V 512		

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V 512	Continued From page 17 - He had spoken with staff #1 after the events of 8/24/22 and was told that FC #1 had struck staff #1 and ran out of the facility to a neighbor's home - It was now apparent staff #1 had failed to provide a full and accurate accounting of what actually occurred - There would have to be a discussion within his agency to determine what steps would be taken next regarding staff #1 Review on 9/20/22 of the Plan of Protection dated 9/20/22 and completed by the QP revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? The staff involved in this incident was removed from the schedule immediately while we completed our investigation. Based on additional incriminating information we terminated the staff person prior to him returning to work. The Client was also removed from the home on 9-7-22 and placed outside of the agency with another provider - Describe your plan to make sure the above happens. The plan to ensure that the client involved remains safe has already been executed. Staff was removed immediately following the incident and the client was moved to another agency." Former client #1's (FC #1's) diagnoses were Intellectual Developmental Disability, Mild, Attention Deficit Hyperactivity D/O, Combined Type; Post Traumatic Stress D/O; Persistent Depressive D/O; and Conduct D/O. FC #1 struck staff #1 in the face knocking his glasses off and breaking them. Staff #1 then hit FC #1, striking him in the head. Client #2 observed staff #1	V 512		

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V 512	Continued From page 18 strike FC #1, intervened and was able to separate the two. After the altercation ended, FC #1 ran outside with staff #1 following behind him and attempting to place him in a restraint. After the restraint ended, FC #1 ran to a neighbor's home where the police were called on his behalf. Photographs taken of FC #1 by a DSS OCSW on the night of the incident revealed red markings on FC #1's face near his right temple and forehead and a mark on his side, which stretched partially across his stomach. The police and the OCSW interviewed staff #1 on the night of the incident and he admitted he struck FC #1. Staff #1 was arrested two days later and charged with aggravated assault and released on bond. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $2000.000 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		