STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601394	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL CHILD	6625 SULLINS ROAD CHARLOTTE, NC 28214

(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 An annual and complaint survey was completed on 02/15/2023. The complaint (intake #NC00195118) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

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V 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 2 Staff (Qualified Professional (QP) and Residential Director) demonstrated competency in knowledge, skills, and abilities required by the population served. The findings are: Review on 01/26/2023 of Client #1's record revealed: -Admitted 11/08/2019. -Diagnosed with Autism Disorder, Obsessive Compulsive Disorder (OCD), Moderate to Severe Intellectual Developmental Disabilities (IDD), Child Disintegrative Disorder, Pica, Attention Deficit Hyperactivity Disorder (ADHD), and Oppositional Defiant Disorder (ODD). -Admission Assessment dated 12/15/2019 revealed: " Competency Status: Incompetent; Presenting Problems: new resident 30 days assessment, however, based on observation, he needs very close one on one; Behavior issues: Aggressive behavior, property destruction,	V 109		

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V 109	Continued From page 2 Self-Injurious Behaviors (SIB) ..." -IDD Risk Assessment dated 05/31/2021 revealed: " ...Communication: Requires full assistance from familiar persons to communicate most or all essential needs ..." Review on 01/26/2023 of Client #2's record revealed: -Admitted 12/08/2022. -Diagnosed with Mild IDD, Post Traumatic Stress Disorder (PTSD), ADHD, and ODD. -Age 15. -Neuropsychological Evaluation dated 01/30/2019 revealed: " ...He has a history of aggressive behaviors toward others ..." -Behavior Support Plan dated 04/22/2022 revealed: " ...Behavior concerns; emotional outbursts, yelling, cursing, making threats, may or may not include property destruction, aggression, and/or elopement ..." Interview on 02/15/2023 with the QP revealed: -Job Title QP. -Hired October 2018. -Ran the day-to-day operations of the facility to include clinical oversight of the program and staff supervision. -Did not complete and/or assign someone to complete an internal investigation immediately after learning of the incident, notify Health Care Personnel Registry (HCPR), Department of Social Services (DSS) or the Local Management Entity/Managed Care Organization (LME/MCO) as required for the incident dated 11/04/2022 for Client #1. -Did not complete an incident report, internal investigation, notify HCPR, DSS or the LME/MCO as required for the incident dated 11/04/2022 for Client #2.	V 109		

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V 109	Continued From page 3 Interview on 02/15/2022 with the Residential Director revealed: -Job Title Residential Director. -Credentialed as a QP. -"I monitor the day-the-day operations of the group home ..." -"I just spoke with Staff #2, and he told me what happened. I did not speak to the school." -Did not contact the school to obtain additional information about the incident dated 11/04/2022 until approximately January 25, 2023. -Did not complete and/or assign someone to complete an internal investigation immediately after learning of the incident, notify HCPR, DSS or the LME/MCO as required for the incident dated 11/04/2022 for Client #1. -Did not complete an incident report, internal investigation, notify HCPR, DSS or the LME/MCO as required for the incident dated 11/04/2022 for Client #2.	V 109		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home	V 132		

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V 132	Continued From page 4 care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on records reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and protect clients during an internal investigation. The findings are: Reviews on 12/08/2022 and 12/09/2022 of the	V 132		

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V 132	Continued From page 5	V 132		

facility records revealed:
-No documentation of an internal investigation or notification to the HCPR for the incident dated 11/04/2022 for Clients #1 and #2 being left unsupervised in a vehicle for approximately 10 minutes by Staff #2.
-No documentation to support that systems were put in place to protect clients after the incident dated 11/04/2022.

Review on 01/26/2023 of a facility document titled "Personal and Confidential" for Staff #2 revealed:
-"...[Staff #2] will be suspended immediately on Monday, 11/07/2022."
-Signed by Staff #2, Qualified Professional (QP), Residential Director, and Chief Executive Officer (CEO)/Owner (O)/Licensee (L) on 11/07/2022.

Interview on 1/30/2023 with Staff #2 revealed:
-On 11/04/2022 informed the Residential Director and CEO/O/L that Client #1 was missing from his vehicle.
-Continued to work 1:1 with Client #2 after the incident on 11/04/2022.
-Was suspended on 11/7/2022 pending an internal investigation for the incident dated 11/04/2022.

Interview on 02/15/2023 with the QP revealed:
-Learned of the incident on 11/04/2022 and began the internal investigation on 11/07/2022.
-Did not put systems in place to protect clients immediately after learning of the incident.
-"It (HCPR notification) did not happen then (prior to survey entrance), but it did happen at some point."

Interview on 02/15/2023 with the Residential Director revealed:
-Learned of the incident on 11/04/2022 and began

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V 132	Continued From page 6 the internal investigation on 11/07/2022. -Did not put systems in place to protect clients immediately after learning of the incident. -"At that time (initially after the incident), it (allegation of neglect) was not substantiated because of the information we had. So, we asked him (Staff #2) to come back to work." Interview on 01/26/2023 with the CEO/O/L revealed: -Learned of the incident on 11/04/2022. -"Yes, we reported it (incident dated 11/04/2022) today (01/26/2023)."	V 132		
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 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	V 366		

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V 366	Continued From page 7 (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 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	V 366		

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V 366	Continued From page 8 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; (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 reviews and interviews, the	V 366		

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V 366	Continued From page 9 facility failed to implement written policies governing their response to level I, II and III incidents affecting 2 of 2 Clients (#1 and #2). The findings are: Reviews on 12/08/2022 of Incident Response Improvement System (IRIS) from 09/01/2022-01/31/2023 revealed: -No Risk/Cause/Analysis or documentation to support submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for Staff #2 leaving Client #1 in the vehicle unsupervised incident dated 11/04/2022. -No incident report, Risk/Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the LME/MCO within five working days for Staff #2 leaving Client #2 in the vehicle unsupervised incident dated 11/04/2022 or for Client #2's attempted assault on staff with a metal bar incident dated 01/26/2023. Interview on 02/15/2023 with the QP revealed: -Did not complete Risk/Cause/Analysis or submit the written preliminary findings of fact to the LME/MCO within five working days for Staff #2 leaving Clients #1 in the vehicle unsupervised incident. -Did not complete incident report, Risk/Cause/Analysis, or submit written preliminary findings of fact to the LME/MCO within five working days for Staff #2 leaving Clients #2 in the vehicle unsupervised incident or for Client #2's attempted assault on staff with a metal bar incident. Interview on 02/15/2023 with the Residential Director revealed:	V 366		

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V 366	Continued From page 10 -Did not complete Risk/Cause/Analysis or submit the written preliminary findings of fact to the LME/MCO within five working days for Staff #2 leaving Clients #1 in the vehicle unsupervised incident. -Did not complete incident report, Risk/Cause/Analysis, or submit written preliminary findings of fact to the LME/MCO within five working days for Staff #2 leaving Clients #2 in the vehicle unsupervised incident or for Client #2's attempted assault on staff with a metal bar incident.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the	V 367		

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V 367	Continued From page 11	V 367		

cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall

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V 367	Continued From page 12 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to report all critical incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 2 of 2 Clients (#1 and #2). The findings are. Observation on 01/26/2023 between 5:20 pm-5:30 pm of Client #2 revealed: -Client #2 walked in and out of the facility several times. Male staff followed behind Client #2. -Client #2 entered the facility again and locked	V 367		

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V 367	Continued From page 13	V 367		

the male staff out of the facility.
-Male staff repeatedly rang the doorbell and Client #2 refused to open the door. Staff #1 eventually opened the door. Client #2 walked in the hall in front of the staff office, which was where Division of Health Service Regulation Surveyor was seated.
-Client #2 had a metal bar in his hands. He swung the metal bar and threatened "to burst staff over the head". Client #2 walked in the staff office with DSHSR Surveyor.
-Male staff attempted to redirect Client #2, but he continued to communicate threats against the male staff and swing the metal bar. Male staff continued to instructed Client #2 to put the weapon down, but he continued with threaten harm against staff.
-Client #2, male staff and Staff #1 walked out of the facility and into the front yard. Client #2 continued to swing the metal bar and threaten to "burst staff over the head".
-Male staff physically engaged and disarmed Client #2.

Reviews on 12/08/2022 and 02/15/2023 of IRIS from 09/01/2022-01/31/2023 revealed:
-Incomplete IRIS report for Staff #2 leaving Client #1 in the vehicle unsupervised incident dated 11/04/2022.
-No IRIS report submitted for Staff #2 leaving Clients #2 in the vehicle unsupervised for incident dated 11/04/2022.
-No IRIS report submitted for Client #2's attempted assault on staff with a metal bar incident dated 01/26/2023.
-No documentation of LME/MCO notifications for Clients #1 or #2.

Interview on 01/26/2023 and 02/15/2023 with the QP revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601394	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL CHILD	6625 SULLINS ROAD CHARLOTTE, NC 28214

(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 367	Continued From page 14 -"[Client #2] has issues beyond our control." -"I don't have an IRIS report for Client #2 being left in the car (unsupervised by Staff #2)." -"We did an internal report (for Client #2's attempted assault on staff) since the police were not called." Interview on 02/15/2023 with the Residential Director revealed: -QP was responsible for completing incident reports.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances	V 500		

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V 500	Continued From page 15 under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged	V 500		

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V 500	Continued From page 16 abuse are reported to the County Department of Social Services (DSS). The findings are: Reviews on 12/08/2022 and 12/09/2022 of the facility records revealed: -No notification to the DSS for the incident dated 11/04/2022 for Client #1 and Client #2 being left unsupervised in a vehicle by Staff #2. Interview on 02/15/2023 with the Qualified Professional revealed: -"It (DSS report) did not happen then (prior to survey entrance), but it did happen at some point." Interview on 02/15/2023 with the Residential Director revealed: -Did not notify DSS of the incident dated 11/04/2022 for Clients #1 and #2 being left unsupervised in a vehicle by Staff #2. Interview on 01/26/2023 with the Chief Executive Officer/Owner/Licensee revealed: -"We did the (DSS) report today (01/26/2023)."	V 500		
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	V 512		

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V 512	Continued From page 17 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 records review and interviews, 1 of 3 audited Staff (#2) neglected 2 of 2 Clients (#1 and #2). The findings are: Review on 01/26/2023 of Client #1's record revealed: -Admitted 11/08/2019. -Diagnosed with Autism Disorder, Obsessive Compulsive Disorder (OCD), Moderate to Severe Intellectual Developmental Disabilities (IDD), Child Disintegrative Disorder, Pica, Attention Deficit Hyperactivity Disorder (ADHD), and Oppositional Defiant Disorder (ODD). -Age 17. -Admission Assessment dated 12/15/2019 revealed: "Competency Status: Incompetent; Presenting Problems: new resident 30 days assessment, however, based on observation, he needs very close one on one; Behavior issues: Aggressive behavior, property destruction, Self-Injurious Behaviors (SIB) ..." -IDD Risk Assessment dated 05/31/2021 revealed: " ...Communication: Requires full assistance from familiar persons to communicate	V 512		

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V 512	Continued From page 18 most or all essential needs ..." Review on 01/26/2023 of Client #2's record revealed: -Admitted 12/08/2022. -Diagnosed with Mild IDD, Post Traumatic Stress Disorder (PTSD), ADHD, and ODD. -Age 15. -Neuropsychological Evaluation dated 01/30/2019 revealed: " ...He has a history of aggressive behaviors toward others ..." -Behavior Support Plan dated 04/22/2022 revealed: " ...Behavior concerns; emotional outbursts, yelling, cursing, making threats, may or may not include property destruction, aggression, and/or elopement ..." Review on 12/12/2022 of Staff #2's personnel record revealed: -Hire date 05/11/2022. -Termination date 01/26/2023. -Job title Direct Support Professional. Reviews on 12/08/2022 and 12/09/2022 of the facility records revealed: -No documentation of an internal investigation for the alleged neglect incident dated 11/04/2022 for Client #1 and Client #2 being left unsupervised in a vehicle for approximately 10 minutes by Staff #2. Reviews on 12/08/2022 of Incident Response Improvement System (IRIS) from 09/01/2022-12/07/2022 revealed: -Only an IRIS report submitted for Staff #2 leaving Clients #1 in the vehicle unsupervised on 11/04/2022 and not Client #2. Review on 12/09/2022 of the Incident Response Improvement System (IRIS) Report for Client #1	V 512		

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V 512	Continued From page 19 revealed: -"Date of Incident: 11/04/2022. -Date Last Submitted: 11/07/2022. -Completed by [Qualified Professional (QP)]. -Provider learned of incident on 11/04/2022. -Location of incident: School. -Other people involved: The Police were involved in locating [Client #1]. -Does this incident include an allegation against the facility? No. -Incident Comments: Organization: Provider. Author: Provider. Date: 11/07/2022. Text: This QP was first made aware of the incident by the resident's mother on 11/04/22 while out of state for a family event. QP received a call from the staff on Sat (Saturday), but due to funeral activities, QP explained that she will investigate the incident after returning on Monday. QP questioned [Staff #2] at 430 pm on 11/7/22 and he reported that he picked up [Client #1] earlier from [local school] and was asked by admin to also pick up another resident from school in [surrounding county]. While at the school, he said he stepped out of the car quickly to a get the other resident from the building entrance and during the process when his back was turned, [Client #1] eloped from the van through the front passenger door. Staff (Staff #2) said he searched the vicinity on and off campus looking for [Client #1]. He noted the search went on for 30 mins (minutes) and as he was about to call the police, he saw some police officers in the back of the school near the bus area and he went up to them to report the incidents. During this time, the police advised him that they had [Client #1] in their possession. QP advised [Staff #2] never to leave a resident in the car for even for a split second as that can pose a serious threat to their health and safety. Organization: Provider. Title: Wandered for 30	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 20 minutes Author: Provider. Date: 11/07/2022. Text: [Client #1] wandered off from the car while on the premises of [Surrounding County School] as the staff stepped away to quickly pick up another resident." -No internal investigative report attached. Review on 01/26/2023 of a document titled "Investigation" dated 01/26/2023 and unsigned revealed: -Incident Date: 11/04/2022. -"Last night, I received a different version of the incident that happened on 11/5/2022 regarding [Staff #2 and Client # 1]. I called the [local high school] this morning and spoke with principal. According to the principal, [Staff #2] came to the school to pick up [client from Sister Facility]. When [Staff #2] got to the school, he was called to office and asked why he was late." Interview on 02/15/2023 with the Principal of Nearby County School revealed: -Incident occurred on 11/04/2022. -"The agency serves a client here (school). While they were picking her up the other resident got out of the car and was found in our parking lot in a diaper. We did not know who the student was, we just knew he was not one of ours. So, we called the police." Interview on 02/15/2023 with the Assistant Principal of Nearby County School revealed: -Incident occurred on 11/04/2022. -"He (Staff #2) walked through the door (of the school). I spoke with him in a conference room, so it had to have been for 5-10 minutes (length of time Staff #2 was in the school building)." -"He (Client #1) was wandering around and our security associate saw him. We could not get close to him, because he was running around."	V 512		

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V 512	Continued From page 21 -Local police were called to assist with Client #1. -"He (Client #1) only had on socks and a diaper." -"He (Staff #2) picked up our student after 5 pm and it was after 6 pm when he came back and started to put the student's clothes back on and placed him in the van." -Emergency Medical Services (EMS) were called to assist Client #1. -"He did have scratches and bruises on his body." -" ...I spoke with Department of Social Services (DSS) about the incident. I think they (DSS) had mentioned that he (Staff #2) said he did not enter our building, which was not true. He entered our building through the side door." -Was not contacted by the facility to discuss the incident. Attempted Interviews on 01/30/2023 and 02/15/2023 with Client #1's Primary Guardian was unsuccessful due to no response to phone call. Interview on 02/15/2023 with Client #1's Co-Guardian revealed: -"I was told that [Client #1] made it out of the car and was gone for a while. I spoke with [Residential Director], and he said there would be additional staff training." -Did not know if EMS evaluated Client #1 on 11/04/2022. Attempted interview on 02/15/2023 with Client #2's Guardian was unsuccessful due to no response to phone call. Attempted interview on 01/26/2023 was unsuccessful due to Client #1 being non-verbal. Attempted interview on 01/26/2023 was unsuccessful due to Client #2's refusal to speak	V 512		

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V 512	Continued From page 22 with Division of Health Service Regulation (DHSR) Surveyor. Interview on 1/30/2023 with Staff #2 revealed: -"My boss (Chief Executive Officer (CEO)/Owner (O)/Licensee (L)) told me that I would be working with another client 1 on 1. I was the only person that [Client #2] could work with. I picked up [Client #2] from school and I was told to pick up [Client #1], and then my boss told me to pick up [Client from Sister Facility]. And I was like how can I pick up [Client from Sister Facility] when I have [Client #2] and [Client #1] with me and no other staff." -"We were running late to pick up [Client from Sister Facility] and [CEO/O/L] and [Residential Director] was calling me to pick up [Client from Sister Facility] ..." -"By the time I got there, I told them (CEO/O/L and Residential Director) to call the school to bring [Client from Sister Facility] out. I stepped out to get [Client from Sister Facility]. My back was turned, and I was talking to the teachers, and they were telling that we are always late to get [Client from Sister Facility] and I told them call my bosses." -"I got back in the car and drove off and then I looked in my rearview mirror and I did not see [Client #1]. I rode around for 30 minutes and then saw the police on a near road and I stopped, and I told them I was looking for a missing kid and I explained how he looked. The police took my id (identification) and wanted [Client #1]'s information. Then they (local police) asked me if I was okay to get [Client #1] and I said 'yeah'. I was looking for [Client #1] on the front side of the school and they had him at the back of the school. I was confused and I did not know what to do, because I was overwhelmed with all those kids. I called my supervisors (CEO/O/L and Residential Director) and explained the situation.	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 23 [QP] was out of town, and I called and informed her." -".. I went inside the school to get [Client from Sister Facility]." -Left Clients #1 and #2 in the vehicle unsupervised while he went inside the school. -Had child locks initiated on the doors of vehicle and Client #1 must have exited the vehicle through the driver's door. -"I did not notice anything (scratches and bruises on Client #1). Client #1 will hit his head and he bite himself. He has those behaviors, and he cannot talk." -"I made an effort to find [Client #1] and nothing happened to him. That was my first mistake and it never happened to me before." Interview on 02/15/2023 with the Qualified Professional revealed: -"I was out of town when [Client #1]'s mom called me." -Was not aware that Client #2 was left in the vehicle unsupervised with Client #1 on 11/04/2022 by Staff #2. -"I was back on Monday (11/07/2022) and I don't remember seeing bruises or scratches on [Client #1]." -Client #1 was not medically evaluated after the incident. Interview on 02/15/2022 with the Residential Director revealed: -"Supervision is 24 hours per day for the Group Home." -Was not aware that Client #2 was in the vehicle unsupervised with Client #1 on 11/04/2022 by Staff #2. -Staff #2 was terminated for neglect on 01/26/2023 after additional information from the school was received on 01/25/2023.	V 512		

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V 512	Continued From page 24 Interview on 1/26/2023 with the CEO/O/L revealed: -"[Staff #2] was terminated today." -"He (Staff #2) was terminated because we got additional information from the school yesterday. So, [Residential Director] terminated him for neglect." Review on 01/27/2023 of the Plan of Protection dated 01/27/2023 and signed by the Residential Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The alleged staff has been terminated as of 01/26/23 and the neglect was substantiated, and his name has been placed on the health care Personnel Registry as of 1/26/23. Any staff that is excused of abuse, neglect and exploration will be immediately suspended pending investigation. During the investigation period, RCA (Royal Child Academy) will protect the resident in question and all other resident's wellbeing. Royal Child will continue to provide 24-hour supervision to ensure the health and safety of residents in our care. All RCA staff have been in-service on abuse, neglect and exploration and in-service took place on 11/10/2022 and 11/17/2022. On 1/26/2023, staff were also in-service on safety protocols as it relates to keeping residents safe at home and in the community and to never leave residents unattended in a car. RCA will facilitate formal training on clients' rights on Tuesday, 2/7/23 and weekly meetings on abuse, neglect, and exploration will be held on 2/2/23, 2/9/23, 2/16/23, and 2/23/23. The legal guardian, local DSS and LME/MCO were informed of the incident and the action taken by RCA against the alleged staff. Describe your plans to make sure the above happens.	V 512		

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V 512	Continued From page 25 A Client Care Specialist has been hired and he is overseeing all client's rights, including protecting clients from abuse, neglect and exploitation. RCA will conduct periodic testing on clients' right as it relates to abuse, neglect, and exploration to enhance staff's knowledge on better supporting the population served." Client #1 was a 17-year-old male diagnosed with Autism Disorder, OCD, Moderate to Severe IDD, Child Disintegrative Disorder, Pica, ADHD, and ODD. He was non-verbal and his risk history included aggressive behavior, property destruction, and self-injurious behaviors. Clients #2 was a 15-year-old male diagnosed with IDD, PTSD, ADHD, and ODD. His risk history included aggression toward others, yelling, cursing, making threats, property destruction, and elopement. Staff #2 left Client #1 and Client #2 in the vehicle unsupervised for approximately 10 minutes as he went into a nearby school to pick up a client from a Sister Facility. Client #2 remained asleep in the vehicle. Client #1 got out of the vehicle, roamed the school parking lot where he was discovered by school officials running around in only his incontinent briefs and socks. Client #1 had scratches and bruises on his body. Staff #2 returned to the vehicle and exited the school without noticing Client #1 missing from the vehicle. Staff #2 came back to the school approximately an hour after his initial departure and retrieved Client #1 from local police. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		