STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-230	A. BUILDING: _____ B. WING _____	05/03/2023

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LIFE-WAY HOMES	1141 AMBERLIGHT CIRCLE SALISBURY, NC 28144

(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 and follow up survey was completed on May 3, 2023. The complaints were substantiated (intake #NC00201021 and intake #NC00201270). Deficiencies were cited. This facility is licensed for the following service 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to meet the individual needs for 1 of 1 Former Client (FC #1). The findings are:

Review on 4/24/23 of FC #1's record revealed:
-An admission date of 12/29/22
-Diagnoses of Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder, Unspecified, and Child or Adolescent Antisocial Behaviors
-Age: 15
-An assessment dated 11/21/22 noted "needs individual counseling, placement at a residential level III, has to continue to learn new coping skills to prepare him for interactions with peers, has to be prepared to make positive decisions in daily interactions with peers and has to continue to learn peer mediation, has to avoid influences by family member and peers, has multiple legal charges pending and needed emergency placement to remove him for a juvenile detention center, previously resided at the detention center for approximately 3 months, has a history of going AWOL (Absent Without Leave) and of being hospitalized. Additionally, it has been reported that the client has a history of physical and verbal aggression, is currently in the custody of DSS (Department of Social Services) but his

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V 112	Continued From page 2 mother is involved in his treatment." -A treatment plan dated 12/29/22 noted "will work on gaining independence by gaining employment, learning how to budget, opening up a bank account and other things to help him progress as a young adult, will attend school on a daily basis and participate in transition skills, complete assigned class work, ask for help as needed and follow the expectations and rules in the classroom by maintaining passing grades and daily attendance, will get a healthy amount of sleep and rest each night by going to bed on time, being quiet after lights out and going to sleep or resting quietly throughout the night, will not exhibit any incidents of inappropriate behaviors, will learn to communicate effectively with peers and adults by adopting effective coping strategies to asset him in managing behaviors, process feelings with adults, reduce the occurrences of displaying inappropriate anger, communicate effectively, be honest and open about his needs without lying and being manipulative and will utilize all coping skills, will working on building positive friendships with peers who can encourage and support him, will learn coping skills to process grief and support through the healing process." -Treatment recommendations included "be placed in a level III group home to provide him with more stability and to ensure that he maintains the safety of himself and others. This placement will provide him with structure 24/7 with rules, routine, structure and will provide psycho-educational interventions based on group-based activities and additional therapy. He and his family need to take part in Family Centered Treatment to increase his ability to cope with environmental stressors, increase natural and community resources and improve functioning and communication with his family system, needs to continue to have his	V 112		

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V 112	Continued From page 3	V 112		

medications managed and monitored by his psychotropic medication management prescriber."
-A detention order, dated 10/20/22 noted " ...must abide by the following terms and conditions during the pre-adjudication release period ...remain on good behavior and violate no local, state or federal law, not violate any reasonable and lawful rules of the juvenile's placements, report to a court counselor, cooperate with treatment ..."
-No goals or strategies to address elopement tendencies
-No goals or strategies to address following the Department of Juvenile Justice (DJJ)'s court order

Review on 4/24/23 of the facility's communication and service notes log revealed:
-2/5/23 "...first room checks were done around 9:45pm. All consumers were in their rooms/beds at this time. At 10:35pm, I did room checks again. [FC #1] was not in his room...911 was called and a missing person report was filed...around 12:25am, [FC #1] returned by ringing the doorbell..."
-Undated note for 3rd shift stated "[FC #1] MIA (Missing in Action). He went AWOL last night and has not returned..."
-2/17/23 "...Around 8:30pm, [FC #1] returned from being AWOL for 3 days ..."

Review on 4/24/23 of the facility's incident reports revealed:
-An incident report dated 2/15/23 at 11am [FC #1] "Asked staff if he could make mop water to continue cleaning his room and was given permission...he bent down and put a note in the door and dropped the bucket and ran ...he went towards [a local road] and staff spotted him in a

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V 112	Continued From page 4 housing neighborhood and called 911..." Interview on 5/1/23 with the Qualified Professional #1 (QP #1) revealed: -Assisted the Licensed Professional (LP) with writing the goals and strategies for the clients' treatment plans -Had not updated FC #1's treatment plan on his elopement tendencies -Was aware FC #1 was on juvenile probation -Had not updated FC #1's treatment plan to follow the DJJ's court order Interview on 4/24/23 with the Licensed Professional (LP) revealed: -Worked with QP #1 to update treatment plans as needed -Had not updated FC's #1's treatment plan Interview on 4/30/23 with the Qualified Professional #2/Doctor of Nursing Practice/Licensee (QP #2/DNP/L) revealed: -Was aware FC #1's treatment plan was to be updated to address his elopement tendencies and following the DJJ's court order -"I will tell you this. From your investigation, I am learning a lot of what has not happened. It is my responsibility (to ensure the clients' treatment plans were updated)... Apparently, [House Manager (HM)] did not contact the LP and complete the treatment plans ...if the goals and strategies are not there, then it was not done ..." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM	V 512		

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V 512	Continued From page 5 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 dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 2 Former Staff (FS #1), 2 of 3 current paraprofessionals (the Team Lead (TL) and the House Manager (HM) and 1 of 2 Qualified Professionals (Qualified Professional #2/Doctor of Nursing Practice/Licensee (QP #2/DNP/L) failed to protect 1 of 1 Former Client (FC #1) and 1 of 2 current clients (client #2) from neglect. The findings are: Review on 4/24/23 of FS #1's record revealed: -A hire date of 1/7/23	V 512		

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V 512	Continued From page 6 -A job description of Direct Care Staff -A separation date of 4/18/23 Review on 4/24/23 of the TL's record revealed: -A hire date of 2/1/23 -A job description of TL Review on 4/24/23 of the HM's record revealed: -A hire date of 1/2/21 -A job description of HM Review on 4/24/23 of the QP#2/DNP/L's record revealed: -A hire date of 1/25/21 -A job description of Licensee - Qualifications to meet the QP status Review on 4/24/23 of FC #1's record revealed: -An admission date of 12/29/22 -Diagnoses of Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder, Unspecified, and Child or Adolescent Antisocial Behaviors -Age: 15 -An assessment dated 11/21/22 noted "needs individual counseling, placement at a residential level III, has to continue to learn new coping skills to prepare him for interactions with peers, has to be prepared to make positive decisions in daily interactions with peers and has to continue to learn peer mediation, has to avoid influences by family member and peers, has multiple legal charges pending and needed emergency placement to remove him for a juvenile detention center, previously resided at the detention center for approximately 3 months, has a history of going AWOL (Absent Without Leave) and of being hospitalized. Additionally, it has been reported that the client has a history of physical and verbal aggression, is currently in the custody	V 512		

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V 512	Continued From page 7 of DSS (Department of Social Services) but his mother is involved in his treatment." -A treatment plan dated 12/29/22 noted "will work on gaining independence by gaining employment, learning how to budget, opening up a bank account and other things to help him progress as a young adult, will attend school on a daily basis and participate in transition skills, complete assigned class work, ask for help as needed and follow the expectations and rules in the classroom by maintaining passing grades and daily attendance, will get a healthy amount of sleep and rest each night by going to bed on time, being quiet after lights out and going to sleep or resting quietly throughout the night, will not exhibit any incidents of inappropriate behaviors, will learn to communicate effectively with peers and adults by adopting effective coping strategies to assist him in managing behaviors, process feelings with adults, reduce the occurrences of displaying inappropriate anger, communicate effectively, be honest and open about his needs without lying and being manipulative and will utilize all coping skills, will working on building positive friendships with peers who can encourage and support him, will learn coping skills to process grief and support through the healing process." -Treatment recommendations included "be placed in a level III group home to provide him with more stability and to ensure that he maintains the safety of himself and others. This placement will provide him with structure 24/7 with rules, routine, structure and will provide psycho-educational interventions based on group-based activities and additional therapy. He and his family need to take part in Family Centered Treatment to increase his ability to cope with environmental stressors, increase natural and community resources and improve functioning and communication with his family	V 512		

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V 512	Continued From page 8	V 512		

system, needs to continue to have his medications managed and monitored by his psychotropic medication management prescriber."

Review on 4/26/23 of client #2's record revealed:
-An admission date of 12/12/22
-Diagnoses of Post-Traumatic Stress Disorder, Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder
-Age: 15
-An assessment dated 12/9/22 noted "has had numerous out of home placements and mental health services, his most recent placement was at [a psychiatric residential treatment center] in [a neighboring state], needs step down placement to a level III, conflict at home with his grandmother and she could not handle his behaviors, difficulty falling asleep."
-An updated treatment plan dated 1/9/23 noted "will participate in recreation therapy activities to improve cognitive, physical, social, emotional team building, hygiene, sportsmanship and independent living skills with same age peers, will get a healthy amount of sleep and rest each night by going to bed on time, being quiet after lights out, and going to sleep or resting quietly throughout the night, will not exhibit any incidents of inappropriate behaviors, will attend school on a daily basis, participate in transition skills, complete assigned class work, as for help as needed, and follow expectations and rules in the classroom by maintaining passing grades and daily attendance, will take medications as directed and appropriately seek medical care when necessary, will actively engage in individual therapy sessions, 90 minutes per week, while completing clinical assignments and activities which address healthy boundaries and socially appropriate behaviors though individual and

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V 512	Continued From page 9 group therapy activities, will demonstrate an increase by community rules and expectations and decrease defiant behaviors in 4 out of 7 days per week." Review on 4/26/23 of the facility's communication log revealed: -"On 4/5/23, second shift, ...[HM] and [QP #2/DNP/L] arrived on site to have a meeting with [FC#1] and [client #2] ...[FC#1] left with [HM] to go to the other home..." Review on 4/26/23 the facility's internal investigation dated 4/5/23 revealed: -"Allegation of [FC #1] and [client #2] having sex. [FC #1] confided in a staff (FS #1) and told her that he and [client #2] had sex while at the group home. [FS #1] called and made the [HM] aware on 4/4/23 of this allegation. [FC #1] indicated that they were playing the game truth or dare. The truth part of the game got boring, so they began to dare each other. An emergency meeting was called on 4/5/23 between [the QP #2/DNP/L], [HM], [FC #1], [client #2] and [staff #2]. [FC #1] expressed that this incident happened a while back (no clarity on exactly when). It is guessed to be a month prior to. [FC #1] stated [client #2] dared him to suck his toe, then suck he ear, then suck his nipple and eventually [FC #1] ended up giving [client #2] oral sex. He initially stated he was forced to 'suck his p***s'. [FC #1] appeared to be shaken and stated he didn't feel safe and didn't want to be in the same space as [client #2] anymore. [FC #1] also made staff aware that [client #2] beat him up so that he would keep quiet about it." Review on 4/26/23, of the facility's in-house report dated 4/6/23 revealed: -"A follow up meeting occurred on 4/6/23 which	V 512		

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V 512	Continued From page 10 included [QP#2/DNP/L], [TL], [HM] [FC #1] and [client #2]. -Summary of evidence that confirms or denies allegation: [FC #1] recanted his initial statement that he was forced (to have sex). It was consensual sex between him and [client #2]. [Client #2] did not deny that something happened, however he was not specific as to what happened sexually between him and [FC #1] ...recommended actions for employer to take: [FC #1] from the facility to a sister facility for safety ...actual actions taken by employer: [FC #1] is no longer in the same home as [client #2] ...date investigation was closed: 4/6/23." Review on 4/26/23 of the facility's level I in-house incident report dated 4/19/23 at 5:55pm and completed by QP#2/DNP/L revealed: -"On the evening of 4/10/23, at 6:00pm, [FS #1] contacted the [HM] and made her aware that [FC#1] confided in her that there had been sexual activity between him and another consumer at the group home (client #2). [QP#2/DNP/L] and [HM] went to the group home (4/10/23) to confront the consumer and in the interim, the consumer denied the allegation and within minutes changed his story and stated he was afraid because he was beat up by the consumer to keep quiet about it. The next day (4/11/23) we met again with [the HM] and [the TL] where the consumer in question (FC #1) was able to explain what happened and [FC #1] recanted his statement and stated that it was consensual sex. For the safety of both consumers, the clinical team (the Licensed Professional, the QP #2/DNP/L and Qualified Professional #1) advised us to separate the two consumers ...so it was determined [FC #1] would be a better fit in another facility...this was discussed during his Child and Family Team meeting (4/11/23) also ...we (the clinical team)	V 512		

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V 512	Continued From page 11 separated the living situations of the consumers (client #2 and FC#1) to ensure safety ...our in-house investigation was conducted and completed with the conclusion of [FC #1] being moved to (a sister facility)." Interview on 4/24/23 with FC #1 revealed: -Admitted he played truth or dare with client #2 -Was unable to recall the date he played the game with client #2 -"When we played it, it led up to us having anal intercourse and I sucked his p***s. He did not like that, so he beat me up in the closet ..." -Staff were downstairs when the sexualized behaviors occurred -"I later told [FS #1] about what happened. I told her not to say anything to anyone." -Had talked to the QP#2/DNP/L about the sexualized behaviors with client #2 -"I told her I did not feel safe, so she moved me to the other facility." Interview on 4/24/23 with client #2 revealed: -"[FC #1] was transferred to another facility because he made a sexual abuse allegation against me. We used to share a room (at this facility). That room is upstairs." -Admitted to getting into a physical altercation with FC #1 "because he told something I told him not to tell. I don't remember what it was though." -Admitted to playing a truth or dare game with FC #1 on one occasion -"We were awake one night and I did not feel like playing truth or dare because I was sleepy ...he started asking weird questions. Questions that were sexual. I told him I was not going for that. I put him in the closet and punched him. This was after the staff had done their bed checks." -Was not sure how often the facility staff conducted bed checks	V 512		

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V 512	Continued From page 12 -FC #1 was close to FS #1 and "talked to her all the time." -"[FS #1] told me [FC #1] liked me and I said 'oh, h**l no.' I don't go for that." -Denied having any sexualized behaviors towards FC #1 -"I don't go for things with dudes. When he made that allegation to staff about me, I wanted to break his face open ...I am just waiting for the truth to come out, so he can look stupid ..." Interview on 4/27/23 with FS #1 revealed: -Had previously worked 2nd shift, from 4pm to 11pm, at the facility -Due to elopement issues and the need for more supervision, FC #1was moved upstairs to share a room with client #2 -On an unknown date, FC #1 confided in FS #1 he was "raped" by client #2 during a game of truth or dare -"I did not report it right away. I was not sure how [client #2] would react once he was made aware of the allegation ..." -Decided to report the sexualized behaviors between client #2 and FC #1 several weeks later, "because I was tired of [FC #1] going into details about what happened ..." -"I don't remember the date but maybe some time in March (2023), I told [TL] about it. He said he would tell [HM] and that she would get to the bottom of it. Nothing happened until April (2023), when [FC #1] was moved to another facility ..." -Stated she sat at the top of the stairs to supervise client #2 and FC #1 on her shift -Had not documented she supervised the clients by sitting outside their bedrooms. Interview on 4/24/23 with the TL revealed: -On 4/11/23, FS #1 made him aware FC #1 had alleged he was "raped" by client #2	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-230	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE-WAY HOMES	1141 AMBERLIGHT CIRCLE SALISBURY, NC 28144

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V 512	Continued From page 13 -"Apparently, [FC #1] confided in [FS #1] about what occurred. I had worked 2nd shift at the facility with [FS #1]. She told me she had a conversation with [FC #1] and that he was infatuated with [client #2]...I then told [HM] and [QP#2/DNP/L] ...we had a meeting on 4/12/23 with the two clients, me, [the QP#2/DNP/L] and [HM] ...it was decided [FC #1] would move to the other facility to keep him separated and safe from [client #2]." -"In my opinion, it (truth or dare) was a game that went too far. And where it went, I am not sure ...a lot of time has gone by since it happened. I am not sure what provoked [FC #1] to say something. But when he did, the flood gates just opened, and everything came out ..." -"The initial allegation was [FC #1] was "raped" by [client #2]. There was no date as to when it occurred. [FS #1] told me she had known about the sexualized behaviors for some time. I asked her why she did not tell me. [FS #1] stated 'I was not working for the agency' when she learned of what happened. I do know it was not recent ..." -"When I talked with [HM] about it, she was saying it was all consensual. We are trying to find out if [FC #1] was harmed and we need to protect him ..." -Facility staff conducted bed checks every 30 minutes -Was not aware FS #1 had sat at the top of the stairs, outside client #2 and FC #1's bedroom to supervise them on her shift Interview on 4/28/23 with the HM revealed: -"[FC #1] made the allegation that [client #2] forced him to suck his p***s. All of this stemmed from them playing truth or dare ...I do not know the date that this happened. It is my understanding the truth part got boring. At some point there were dares that were sexual in nature	V 512		

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V 512	Continued From page 14 ...like suck my toe, suck my nipple and then it ended with oral sex. That is what [FC #1] said. [Client #2] denied anything happening ...I learned of the allegation towards the end of March (2023) and going into April (2023) ...we had a meeting at the office and present was me, [QP#2/DNP/L), [TL] and both of the clients. After the meeting we separated them and [FC #1] was transferred to another facility ...I think the incident happened several months ago." -Did not know why the two clients were not separated immediately -"This all came out when [FC #1] confided in [FS #1]. She did not tell us about it until much later. I heard that [FS #1] told [TL] and he did not tell anyone about it. I don't know why he did not address it ..." -Was told by FS #1 that sexualized behaviors had occurred between the two clients (client #2 and FC #1) -"I went straight to [the QP#2/DNP/L] and talked to her about it. I thought it was consensual sex between them." -Staff were to document the bed checks every 15 minutes Interview on 4/25/23 with the QP #2/DNP/L revealed: -Learned FS #1 knew about the sexualized behaviors between client #2 and FC #1 for several weeks and did not report it -" ...As soon as I learned of the incident, I called [HM]. I believe this was in March (2023). I went immediately to the facility. I sat down with [HM], [client #2] and [FC #1]. [HM] looked into the issue and stated since it was consensual, we could close out our investigation..." -Terminated FS #1 on 4/18/23 -"She was the one that [FC #1] told about the sexualized behavior and she held onto that	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 15 information for a while. I don't know when the incident occurred between the clients, but we learned about it on either the 4th or 5th of April (2023) ...when I learned about the incident, I called [HM] and she told me she already knew about it. She said she was made aware of the sexualized behaviors on Sunday, the 2nd of April (2023) ..." Review on 5/3/23 of the facility's Plan of Protection (POP), dated 5/3/23 and completed by the Licensed Professional (LP) and the Chief Financial Officer (CFO) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Lifeway Homes, LLC ("LWH") has terminated on May 1, 2023, the services of the House Manager who was in charge of making the report of the incident between the two consumers [client #2] and [FC #1], and who failed to report the incident. Additionally, LWH has separated the two consumers by moving [FC #1] away from the residence. We have also limited any type of one-on-one interactions between [client #2] and [FC #1]. Further, LWH will ensure that the staff is trained no later than May 10, 2023, to report and document all such incidents at the home. The documentation must then be provided to the QP to review and sign off on. The LP is aware of the allegations and will supervise the Plan of Protection. [The LP] will then report to Management. Immediately (05/03/23), LWH through the LP will retrain all staff about abuse and neglect incidents, retrain them on reporting allegations of abuse and neglect; and retrain the staff on the levels of incidents and the time frame for reporting. LWH will retain staff on supervision policy no later than May 10, 2023. LWH will increase the frequency of bed checks to 15-minute interval, and the staff must put their	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 16 names besides the slot, commencing on May 3, 2010. LWH will ensure that its LP is responsible for following the POP. -Describe your plans to make sure the above happens. On April 27, 2023, even prior to the issuance of this POP, LWH had a lengthy training with the staff and supervised by the LP. The training focused mainly on reporting and documenting incidents at the home. LWH will continue to train its staff to make sure we are in compliance with the rules and regulations, with the main goal being the safety and welfare of the consumers. The LP will ensure that all of this happens. None of the individuals cited is a part of the Plan of Protection. Additionally, as stated, LWH has separated the two consumers by moving [FC #1] away from the residence. We have also limited any type of one-on-one interactions between [client #2] and [FC #1]. Further, LWH will continue to ensure that the staff is trained to report and document all incidents of this type at the home. The documentation must then be provided to the QP to review and sign off on. [The LP] will then report to Management. LWH will ensure that its LP is responsible for following the POP." The facility served minor children with diagnoses not limited to: Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, Child or Adolescent Antisocial Behaviors, Post-Traumatic Stress Disorder, and Unspecified Trauma and Stressor Related Disorder. FC #1 and client #2 engaged in alleged sexualized behavior. FC #1 disclosed this information to FS #1 on an unknown date. After she got tired of FC #1 talking about the behaviors, she then made the decision to inform the TL about FC #1's allegation of sexualized behaviors with client #2.	V 512		

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V 512	Continued From page 17 The TL stated he would inform the HM of the alleged incident. When the TL failed to immediately report the sexualized behaviors, FS #1 told the HM. The HM stated she became aware of the situation on April 2, 2023. The HM failed to report the information immediately to the QP #2/DNP/L. She informed the QP #2/DNP/L on either April, 4th or April 5th, 2023 of the alleged sexualized behaviors. The HM stated she thought the sexualized behaviors were consensual, so she waited to report it. The facility failed to put protective measures in place to address the allegation of sexualized behavior between the two clients when they became aware of the allegation. These failures constitute serious neglect on part of FS #1, the TL, the HM and QP#2/DNP/L. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 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		