STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411092	A. BUILDING: _____ B. WING _____	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYALTY CARE	2205 FOREST EDGE DRIVE GREENSBORO, NC 27406

(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 survey was completed on October 30, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 and currently has a census of 1. The survey sample consisted of audits of 1 current client.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall	V 110		

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V 110	Continued From page 1 develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 2 of 2 paraprofessionals (staff #1 and the Alternative Family Living (AFL) Provider)) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Review on 10/27/23 of staff #1's record revealed: -A hire date of 1/1/22 -A job description of Paraprofessional Review on 10/27/23 of the AFL Provider's record revealed: -A hire date of 4/2/20 -A job description of AFL Provider Review on 1/24/23 of client #1's record revealed: -An admission date of 2/1/20 -Diagnoses of Autistic Disorder, Hypercholesterolemia, Profound Intellectual Disability Disorder, Depression and Attempts of Self-Harm -Age: 24 -An assessment dated 2/1/20 noted "is non-verbal, requires 24-hour supervision without awake staff, uses gestures, points and some sign language when trying to communicate ...needs on-going assistance to manage negative behaviors including self-injury, assaultive	V 110		

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V 110	Continued From page 2 behaviors, self-stimulation and elopement, has limited abilities in self-help areas such as dressing, toileting and bathing, cannot manage impulsive behaviors that at times result in aggression, and needs stabilization of his behaviors which require intensive monitoring ..." Review on 10/27/23 of client #1's safety supports needed in the home and community, dated 12/1/19, revealed: -"Requires partial supports to regulate water temperatures, requires some supports for close supervision due to risk of wandering away, requires some supports due to the inability to make safe choices when in the home (e.g. not putting metal in the microwave or toaster, not opening the door to strangers), requires full support to prevent victimization in the home or community, requires full support to make safe choices (e.g. crossing the street, refusing rides from strangers), requires full support to evacuate the home in an event of a fire, requires full support to access help in emergencies, requires full support due to inability to avoid being taken advantage of financially, and requires 24 hour supervision to ensure his safety." Attempted interview on 10/26/23 at 1:18pm with client #1 revealed: -Was not able to respond to any questions as he was non-verbal Further observations on 10/27/23 from 9:57am to 12:51pm of client #1 revealed: -From 9:57am to 10:02am the AFL Provider went outside and left client #1 alone, upstairs, in the facility -From 10:14am to 10:25am the AFL Provider went outside and left client #1 alone, upstairs, in the facility	V 110		

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-During this time, client #1 came down the stairs and peeped out the living room window.
-Client #1 made noises and then went back upstairs
-At 11:02am, the AFL Provider went back outside, and left client #1 alone upstairs until 11:11am
-During this time, client #1 could be heard flushing the toilet and running water in the upstair's bathroom
-At 12:49pm, the AFL Provider went outside and left client #1 unsupervised upstairs
and returned at 12:51pm

Interview on 10/27/23 with the Division of Health Service Regulation (DHSR)'s Biennial Residential Team Leader (BRTL) with the Construction Section revealed:
-Had an appointment with the AFL Provider on 10/26/23 at 1:30pm for a follow up survey
-Arrived (early) at 11:45am on 10/26/23
-Was not able to get anyone to the door of the facility
-Noticed a male's face "peeking out of the facility's window."
-Did not see any staff at the facility
-The AFL Provider reported "his cousin was upstairs in the shower at the facility and the client was not home alone."
-The AFL Provider arrived at the facility at 12:34pm
-"We told him we needed to see the master bedroom. He went halfway up the stairs and yelled to her (the female cousin) to see if she was finished with her shower. Then he went upstairs and told us he had moved her from the master bedroom to another bedroom and we could come upstairs."
-"We never did see his female cousin."
-The AFL Provider identified the male as client #1

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V 110	Continued From page 4 Interview on 10/27/23 with client #1's Care Coordinator revealed: -Client #1 had a history of self-harming, physical aggression and elopement and required 24-hour supervision -Would have concerns if client #1 was alone at the facility -"One (concern) would be harm to himself. That would be due to him being destructive at times and for elopement issues. He's non-verbal. He can understand the things you say. He would not be able to call 911." Interview on 10/30/23 with client #1's Legal Guardian (LG) revealed: -Client #1 had a history of self-harming, physical aggression and elopement and required 24-hour supervision -"He (client #1) knows how to lock and unlock the front door and could have wandered off. He's nonverbal and would not know what to do in case of an emergency." Interview on 10/26/23 with staff #1 revealed: -Work hours at the facility were from 9am to 3pm Monday through Friday and some weekends -Worked on 10/26/23 at the facility -Had to make an emergency dental appointment on 10/26/23 -Called the AFL Provider (time not known) regarding the issue with his tooth -The AFL Provider told him to go ahead and leave the facility "because he was on his way from [a city] 20 minutes away." -"I left the facility at about 11:45am to head to my dentist in [a neighboring state]. I left [client #1] alone as [AFL Provider] was on his way to the facility." -Was aware client #1 was non-verbal and required supervision in the facility and the	V 110		

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V 110	Continued From page 5	V 110		

community
-"It's not like it's a continuous thing to leave [client #1] alone."

Review on 10/30/23 of a photograph of staff #1's mouth texted to the AFL Provider revealed:
-No date was on the photograph
-The photograph showed an open mouth with a finger pointing at a tooth on the lower left jaw

Review on 10/30/23 of a work release form, dated 10/29/23, from staff #1's emergency room visit revealed:
-"This notice verified that the above-named employee was seen and treated in our emergency room department on the above printed date. The employee will be able to return to work one day from 10/29/23."
-A handwritten notation for the date of return to work on 10/31/23
-The emergency room was located in an adjoining state

Interview on 10/27/23 with the Qualified Professional (QP) revealed:
-Was aware client #1 was non-verbal and required supervision while in the facility and the community
-Was made aware by the AFL Provider that staff #1 had left client #1 unattended on 10/26/23
-Client #1 was nonverbal and was to have staff present with him "24 hours a day."
-Was not aware the AFL Provider told staff #1 to go ahead and leave the facility with client #1 unsupervised
-"Well, that changes things."

Further interview on 10/30/23 with the QP revealed:
-Had "counseled" the AFL Provider and reviewed

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V 110	Continued From page 6	V 110		

"the policies" with him on 10/29/23
-The AFL Provider had a written warning on 10/29/23 for leaving client #1 alone and unsupervised in the facility
-Planned to counsel staff #1 today (10/30/23) on "the same things."

Review on 10/30/23 of the AFL Provider's written statement, dated 10/29/23 and provided by the QP revealed:
-"I, [the AFL Provider] gave [staff #1] the okay to leave to go to the dentist due to his tooth pain."

Interview on 10/26/23 with the AFL Provider revealed:
-Was aware client #1 was nonverbal and required supervision
-Arrived at the facility on 10/26/23 at approximately 12:30pm as DHSR construction surveyors had called him stating they were early for the scheduled 1:30pm visit
-Had received a call from staff #1 earlier in the day on 10/26/23
- "[Staff #1] had an emergency and needed to see the dentist as he complained of his tooth hurting."
-Was in another city on 10/26/23 approximately 20 miles away when staff #1 called him
-Told staff #1 to go ahead and leave the facility with client #1 inside
-"I know it was an emergency for [staff #1]. It is not acceptable that [client #1] was left alone, but I was already on my way to the facility."
-Felt client #1 could be left alone for 15 minutes
-"I know I am in violation ...I know he is (capable of staying alone) but it is not documented."
-"My female cousin was upstairs in the shower when the surveyors (DHSR construction section) got to the facility. She wasn't feeling well and didn't want to open the door to strangers."
-Was unable to provide the full name of his

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V 110	Continued From page 7 female cousin -Was unable to provide a contact number for his female cousin -"She is in and out of the house. She doesn't live here but she has some housing problems." Further interview on 10/30/23 with the AFL Provider revealed: -Staff #1 went to the emergency room on 10/29/23 -The photograph staff #1 sent him via text message was received on 10/25/23 "late at night." -Reported he was unable to pinpoint the time of the text because he "deletes [his] texts." -"[Staff #1] told me his tooth was killing him and he would try to work on Thursday (10/26/23)." -His female cousin was at the facility on 10/26/23 at 11am, "to take a shower and then she left." This deficiency is cross referenced into 10A NCAC 27D. 0304 Protection from Harm, Abuse, Neglect or Exploitation for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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	V 112		

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V 112	Continued From page 8 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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility staff failed to implement strategies or goals in the treatment/habilitation plan to address the needs of 1 of 1 client (#1). The findings are: Observations on 10/26/23 at approximately 2:05pm of the kitchen revealed: -A side by side refrigerator/freezer with double handles -A flexible black cable cord that wrapped around and through the double handles -The cable cord had a combination lock -The AFL Provider unlocked the refrigerator/freezer to get a drink out for client #1 Review on 1/24/23 of client #1's record revealed:	V 112		

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V 112	Continued From page 9 -An admission date of 2/1/20 -Diagnoses of Autistic Disorder, Hypercholesterolemia, Profound Intellectual Disability Disorder, Depression and Attempts of Self-Harm -Age 24 -No documentation of a history which would indicate a need of a lock placed on the food items -There were no strategies or goals in client #1's treatment plan to address why client #1 needed a combination lock on the double handles of the refrigerator/freezer Attempted interview on 10/26/23 with client #1 revealed: -Was non-verbal Interview on 10/30/23 with client #1's Legal Guardian revealed: -Client #1 had a history of going into the refrigerator and eating "everything he can get his hands on. He did it all the time when he lived with me." -Was not aware the AFL Provider had locked the refrigerator/freezer so client #1 would not have access to food Interview on 10/30/23 with the Qualified Professional (QP) revealed: -Was responsible for completing goals and strategies in client #1's treatment plan -The treatment plan for client #1 did not document the need for the combination lock on the refrigerator/freezer -"We (the LG, the AFL Provider and the QP) had discussed it a few months ago because [client #1] would consistently go back and forth from his room to the refrigerator (to get food out). We were going to add this to his treatment plan."	V 112		

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V 112	Continued From page 10 Interview on 10/26/23 with the AFL Provider revealed: -Had put the combination lock on the refrigerator/freezer "several years ago." -Client #1 went into the refrigerator/freezer and "tries to eat anything he can get his hands on, including frozen foods." -Was not aware client #1's restriction to access food needed to be in his treatment plan	V 112		
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 dismissal of the employee.	V 512		

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V 512	Continued From page 11 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 2 of 2 paraprofessionals (staff #1 and the Alternative Family Living (AFL) Provider) neglected 1 of 1 client (#1). The findings are: Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (Tag V110). Based on observations, record reviews and interviews, 2 of 2 paraprofessionals (the Alternative Family Living (AFL) Provider and staff #1) failed to demonstrate the knowledge, skills and abilities required for the population served. Review on 10/26/23 of the facility's plan of protection, dated 10/26/23 and written by the AFL Provider revealed: -"What immediate action will the facility take to enusre the safety of the consumers in your care? I will remain her until [staff #1] can return to work with consumer. -Describe your plans to make sure the above happens. I'm going to stay here 24 hours." Review on 10/30/23 of the facility's second plan of protection, dated 10/30/23 and written by the Qualified Professional (QP) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Counseling with the AFL provider review policies. 90-day monitoring, and unannounced visit by QP. On October 29, 2023, I counseled the AFL provider on our policies of abuse and neglect. I immediately contacted [staff #] on 10/30/23 and review the policies, procedures and neglect part with him over the phone. -Describe your plans to make sure the above happens. Monitoring, unannounced visits. And	V 512		

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V 512	Continued From page 12 reviewed this incident for the next 90 days during supervision. I will continue to come announce to the home and note all of my visits. And if staff have to leave, they will take [client #1] with them and meet the current staff that is on shift. I have also added additional staff for [client #1]." Client #1 was nonverbal, required 24-hour supervision while in the facility and had a history of elopement. The AFL Provider and staff #1 were aware of client #1's need to have 24-hour supervision while in the facility. On 10/26/23, staff #1 had a dental emergency and had to leave. The AFL Provider stated he told staff #1 to go ahead and leave the facility as he was on his way there. On 10/26/23, client #1 was left unsupervised at the facility from approximately 11:45am until the arrival of the AFL Provider at approximately 12:34pm. This left client #1 alone at the facility with no staff for approximately 49 minutes. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 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		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement	V 513		

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V 513	Continued From page 13 skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide services using the least restrictive and most appropriate methods affecting 1 of 1 client (#1). The findings are: Observations on 10/27/23 at approximately 2:05pm of the kitchen revealed: -A side by side refrigerator/freezer with double handles -A flexible black cable cord that wrapped around and through the double handles -The cable cord had a combination lock -The AFL Provider unlocked the refrigerator/freezer to get a drink out for client #1 Review on 1/24/23 of client #1's record revealed: -An admission date of 2/1/20 -Diagnoses of Autistic Disorder,	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411092	A. BUILDING: _____ B. WING _____	10/30/2023

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V 513	Continued From page 14 Hypercholesterolemia, Profound Intellectual Disability Disorder, Depression and Attempts of Self-Harm -Age 24 -No documents were signed by client #1's Legal Guardian (LG) that a combination lock should be installed on the handles of the refrigerator/freezer Interview on 10/30/23 with client #1's LG revealed: -Client #1 had a history of going into the refrigerator and eating "everything he can get his hands on. He did it all the time when he lived with me." -Was not aware the AFL Provider had locked the refrigerator/freezer -Had not given permission to the AFL Provider to restrict client #1's access to the refrigerator/freezer Attempted interview on 10/26/23 with client #1 revealed: -Was non-verbal Interview on 10/30/23 at 1:40pm with the Qualified Professional revealed: -Was not aware the refrigerator/freezer's handles had the combination lock on it, that restricted client #1's access to food -"It (the combination lock) was brought up a few months ago ...we were going to add it (the restriction) to his treatment plan." -"The LG was aware, and we got approval from her and the care coordinator (to put the lock on the refrigerator/freezer's handles), but I haven't had time to put it in [client #1]'s treatment plan." Interview on 10/27/23 with the AFL Provider revealed: -Had put the combination lock on the	V 513		

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V 513	Continued From page 15 refrigerator/freezer "several years ago." -Client #1 went into the refrigerator/freezer to "eat anything he can get his hands on, including frozen foods."	V 513		