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(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 28, 2024. The complaint was substantiated (intake #NC00217082). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to keep the MARs current affecting two of three audited clients (#2 and #3). The findings are: Review on 5/21/24 of client #2's record revealed: -Admission date of 12/31/75 -Diagnoses of Mild Intellectual Disability, Hypertension, Congenital Hypothyroidism, Obesity, Osteopenia, Dysthymic Disorder, Chronic Kidney Disease, Edema, Overactive Bladder, Heartburn, Neuropathy in foot and Gout Review on 5/21/24 of client #2's physician's order dated 9/14/23 revealed: -Omeprazole 20 milligrams (mg) (Heartburn), one capsule daily -Aspirin 81 mg (Anti-inflammatory), one tablet daily -Enalapril 10 mg (Hypertension), one tablet daily -Check Blood Pressure daily Review on 5/21/24 of MARs for client #2 revealed: April 2024:	V 118		

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V 118	Continued From page 2 No staff initials as administered or checked for the following: -Omeprazole 20 mg on 4/25 -Aspirin 81 mg on 4/17 -Blood Pressure checks on 4/22, 4/18 and 4/17 March 2024: No staff initials as administered or checked for the following: -Omeprazole 20 mg on 3/7 -Aspirin 81 mg on 3/6 and 3/7 -Enalapril 10 mg on 3/7 -Blood Pressure checks on 3/7 and 3/8 Review on 5/21/24 of client #3's record revealed: -Admission date of 10/2/06 -Diagnoses of Mild Intellectual Disability, Type II Diabetes, High Blood Pressure, Chronic Migraines, Chronic Kidney Disease, Insomnia, Chronic Right Side Heart Failure, Depression and High Cholesterol Review on 5/21/24 of client #3's physician's order dated 8/9/23 revealed: -Torsemide 20 mg (Diuretic), one tablet daily -Paroxetine 20 mg (Depression), one tablet daily -Renewal Cream (Moisturizer), apply to feet, heels and hands twice a day Review on 5/21/24 of MARs for client #3 revealed: April 2024: No staff initials as administered for the following: -Paroxetine 20 mg on 4/14 thru 4/17 -Renewal Cream on 4/17	V 118		

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V 118	Continued From page 3 March 2024: No staff initials as administered for the following: -Torsemide 20 mg on 3/13 Interview on 5/21/24 with the Division Director revealed: -Client #2 went to visit her family in March 2024. -Staff forgot to indicate the home visits on her March 2024 MAR. -Staff administered client #3's medication. -Staff "possibly" forgot to sign off on client #3's MAR. -There were no issues with clients #2 and #3 getting their prescribed medications. -She confirmed the MARs were not kept current for clients #2 and #3. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
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	V 512		

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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, one of three audited staff (#1) abused and neglected one of three audited clients (#1) and one of three audited staff (The Group Home Manager) failed to protect one of three audited clients (#1) from abuse and neglect. The findings are:

Review on 5/21/24 of personnel records for staff revealed:

Group Home Manager:
-Date of hire was 1/16/23.

Staff #1:
-Date of hire was 8/9/23
-Hired as a Skills Trainer.

Review on 5/21/24 of client #1's record revealed:
-Admission date of 12/2/85.
-Diagnoses of Mild Intellectual Disability, Major Depressive Disorder, Cognitive Impairment, Dementia, Down's Syndrome, Gastroesophageal Disease, B12 Deficiency, Anxiety Disorder, Plantar Fasciitis and Hearing Loss.

Review on 5/21/24 of in-house incident reports for client #1 revealed:

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V 512	Continued From page 5 -5/13/24-Report written by the Group Home Manager-"[Staff #1] came to get [client #1] up and ready this morning. She was able to get her into the bathroom and undressed. That's when we saw that she had a bowl movement on herself and needed a shower. [Client #1] had feces on her from the wrist down and started grabbing it from her private area and smearing it. It was all over her face, hands, and in her hair as well. [Staff #1] called me from the room to come and assist her with the shower. [Client #1] began to get combative and aggressive and kept trying to go into the dining room. We got her back in the bathroom and into the shower, but as soon as the water was turned on she began to scream, grabbed me by my clothes, and got feces all over me as well. The situation was very stressful so we turned off the water and let her out of the shower and she tried again to go into the kitchen, but [Staff #1] stopped her. I stepped away to change my clothes and called via phone, [the Division Director] to come and assist...[Staff #1] had grabbed a chair and sat in front of the door to prevent [client #1] from coming out. This was a one time isolation measure to keep her from coming out in the condition she was in." -5/13/24-Report written by Staff #1-"I came in this morning to get [Client #1] up. When I got her into the bathroom and got her undressed, I saw that she was covered in poop. I knew she needed a shower and from past experiences I knew she wasn't going to let me do it so I called [the Group Home Manager] for assistance. When we got her into the shower she became combative and was hitting at us. [Client #1] got poop on [the Group Home Manager] and was not being cooperative. It was a stressful situation and we needed assistance. We called [the Division Director] by	V 512		

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phone for help. We put a chair in front of the door for the safety of us and [Client #1's] housemates, given she was naked and covered in feces from head to toe and being aggressive trying to leave the bathroom. We made sure to check on her to be sure she was safe also."

Client #1 could not be interviewed because she was in the hospital.

Interview on 5/22/24 with client #4 revealed:
-She saw some of the incident with client #1, staff #1 and the Group Home Manager.
-Client #1 was walking around the facility screaming and hollering.
-Staff #1 told her to get a chair from the dining room area.
-Staff #1 took the chair and put it in front of the bathroom door.
-The bathroom door was closed.
-Staff #1 sat in the chair while it was in front of the door.

Interview on 5/22/24 with staff #1 revealed:
-There was an incident with client #1 about a week ago (5/13/24).
-She went into client #1's bedroom to get her up.
-She could smell "poop" as soon as she walked into her bedroom.
-She took client #1 into the bathroom and saw "poop" all over her body.
-She took off client #1's clothes.
-She called the Group Home Manager into the bathroom because she needed help.
-They got client #1 into the shower.
-They turned on the water and client #1 became combative.
-Client #1 was screaming and hitting them.
-Client #1 got "poop" on the Group Home Manager.

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-The Group Home Manager stepped out of the bathroom to call the Division Director.
-Client #1 tried to leave the bathroom and was told she could not leave the bathroom.
-She asked client #4 to bring her a chair.
-She set the chair in front of the door for the safety of client #1 and the other clients.
-Client #1 was trying to get out of the bathroom and go into the kitchen where the other clients were eating.
-Client #1 was also being "combative."
-The door to the bathroom was cracked and she was standing outside of the bathroom.
-Client #1 remained in the bathroom.
-She could see client #1 through the crack of the door in the bathroom.
-Client #1 had "poop" all over her hands and she didn't want her to hit or touch the other clients with "poop" on her hands.
-The chair was in front of bathroom door for "about" 10 minutes.
-The chair was never placed underneath the doorknob to the bathroom door.
-She may have closed the door all the way for a minute or two while client #1 was in the bathroom because she had to go into her bedroom and clean up.
-She or the Group Home Manager stood outside the door while client #1 was in the bathroom the "majority" of the time.
-The Care Coordinator with the Local Management Entity/Managed Care Organization (LME/MCO) was at the facility that morning as well.

Interview on 5/22/24 with the Group Home Manager revealed:
-There was an incident with client #1 last Monday (5/13/24).
-Staff #1 got client #1 out of bed and took her to

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the bathroom.
-Staff #1 discovered client #1 had feces on her.
-Staff #1 took client #1 into the bathroom and called for assistance.
-Client #1 was "combative and aggressive" while they tried to get her undressed.
-They got client #1 undressed and got her in the shower.
-Client #1 then started yelling, screaming and kicking.
-"[Client #1] grabbed me and got feces all over me."
-Client #1 kept fighting and they turned the water off and let her out of the shower.
-Client #1 "took off" and tried to leave the bathroom.
-Staff #1 "blocked" the doorway to keep client #1 from leaving the bathroom.
-Client #1 "got mad, started kicking, screaming, and tried to fight her way out of the bathroom."
-She told staff #1 she needed to call the Division Director because "the situation had gotten out of control."
-She stepped out of bathroom.
-She also needed to change her clothes.
-She went back to bathroom and the door was cracked slightly with a chair in front of the door.
-The chair was not underneath the bathroom doorknob.
-She told staff #1 the Division Director was on her way.
-Client #1 was still in the bathroom.
-Staff #1 was standing outside of the bathroom looking at client #1 through the crack of the door.
-Staff #1 said "I'm not fighting with her anymore, I'm going to leave the chair here until [the Division Director] comes."
-Staff #1 had to help one of the other clients and she also stood in front of the door and monitored client #1 while she was in the bathroom.

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V 512	Continued From page 9 -She didn't go back into the bathroom either because she was assisting the other clients as well with medication. -She "thought" the chair was in front of door for "about" 15 minutes. -Staff #1 moved the chair from in front of door prior to the Division Director arriving. Interview on 5/22/24 with the Care Coordinator with the LME/MCO revealed: -She was at the facility on 5/13/24 when she witnessed an incident. -She was the Care Coordinator for two of the other clients residing in that facility. -She was sitting at the table in the kitchen area and doing a monitoring visit with client #6. -The Group Home Manager and staff #1 were also at the facility. -They were all in the kitchen area. -She saw a chair pushed up against the bathroom door. -The chair was pushed underneath the doorknob. -"I thought maybe staff were cleaning the facility." -She had been sitting in the kitchen area for about 20 minutes or longer with the Group Home Manager and staff #1. -She saw one of the staff go to the bathroom, move the chair and open the door and started talking to someone. -She heard that staff say client #1's name. -She asked the staff if she was talking to client #1 and staff replied "yes." -She had no idea client #1 was in that bathroom while the chair was pushed up against the knob. -She told staff they could not do that. -She told staff they were not allowed to "confine" a client in the bathroom. -She never saw staff go to the bathroom prior to that to check on client #1. -Staff said client #1 had behaviors and was being	V 512		

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"combative."
-She talked with the Division Director about the incident.
-She told the Division Director what she witnessed while she was at the facility.
-She (the Care Coordinator) used to work for that agency and was the Former Division Director for that facility.
-"I know the clients well at that facility."

Interview on 5/21/24 with the Division Director revealed:
-On 5/13/24 the Care Coordinator with the LME/MCO reported staff confined client #1 in the bathroom with a chair in front of the door.
-The Care Coordinator with the LME/MCO was at the facility earlier that morning visiting a client.
-She was not working during that incident.
-The Group Home Manager and staff #1 were the two staff working during that incident.
-Both staff assisted client #1 when the incident occurred.
-She was told by staff client #1 was covered from head to toe in "poop."
-Staff also said client #1 had some "combative" behaviors during that incident.
-Staff #1 placed the chair in front of the bathroom door.
-She was told the chair was not underneath the door handle.
-Staff #1 said she put the chair near the bathroom door and left the door cracked.
-Staff #1 said the chair was there to keep client #1 safe.
-She was told the Group Home Manager had to step away and clean up because she had feces on her.
-She was told the other clients were in the kitchen area eating breakfast.
-Staff #1 said she didn't want client #1 to come

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V 512	Continued From page 11 out of the bathroom and spread feces. Interview on 5/21/24 with the Assistant Director revealed: -She was aware of the incident on 5/13/24 with client #1, staff #1 and the Group Home Manager. -The Care Coordinator with the LME/MCO for other consumers was at the facility. -The Care Coordinator with the LME/MCO called the Department of Social Services because she had some concerns. -It was "alleged" staff locked client #1 in the bathroom. -She was told staff #1 put a chair in front of the bathroom door. -She was also told staff #1 never put the chair underneath the knob to the bathroom door. Interview on 5/23/24 with the Executive Director revealed: -She was aware of the incident on 5/13/24 with client #1, staff #1 and the Group Home Manager. -The Assistant Director talked with her about the incident. -She did not talk with staff about that incident because she was on vacation when that incident occurred. -The Assistant Director addressed that incident with staff. Review on 5/23/24 of a Plan of Protection written by the Executive Director dated 5/23/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? I will immediately put the two staff involved on administrative leave pending conclusion of this investigation. Based on all findings from the current investigations, we will make the decision to either terminate staff or discipline and retrain staff on Clients Rights, Abuse and Neglect, and	V 512		

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Incident Reporting, and any other areas needed to make sure that they are fully competent. In addition, we will continue to work with the residents to understand fully their rights, and that they should report any time that they feel abuse or neglect may be taking place. Describe your plans to make sure the above happens. I have already contacted the two staff involved to inform them that they are on administrative leave immediately pending conclusion of the investigations. I have let them know that we will be making a determination with our administrative staff as to the actions that need to be taken when all that information is compiled. At that time, they will face disciplinary action up to and including termination of their employment. We train all staff on client rights, abuse and neglect and incident reporting annually as needed. The pieces for making sure consumers are advised of their rights are in place, but we will go over these again, and going forward. Client rights and reporting numbers are already posted in the house, and we will make sure that all consumers are familiar with the locations and understand the purpose."

Client #1's diagnoses included Mild Intellectual Disability, Major Depressive Disorder, Cognitive Impairment, Dementia, Down's Syndrome, Anxiety Disorder and a Hearing Loss. On 5/13/24 the Group Home Manager and Staff #1 took client #1 into the bathroom at attempt to assist with bathing her as client #1 was covered in feces. Client #1 became combative with staff and got feces on the Group Home Manager. The Group Home Manager left the bathroom, called the Division Director and changed her clothes. Staff #1 left client #1 in the bathroom alone and unsupervised. Staff #1 put a chair underneath the doorknob to the bathroom which prevented client

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS AVENUE GROUP HOME	4425 REGIS AVENUE DURHAM, NC 27705

(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 512	Continued From page 13 #1 from leaving the bathroom for at least 20 minutes. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days.	V 512		