Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-516	A. BUILDING: _____ B. WING _____	R-C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSHAUN'S HOUSE OF CARE	4012 GUESS ROAD 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 000	INITIAL COMMENTS A complaint and follow up survey was completed on June 3, 2024. The complaint was substantiated (intake #NC00217322). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 5 current clients.	V 000		
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 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	V 132	RECEIVED BY MHL & C 6/27/24	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Roshaun Willis TITLE Owner (X6) DATE 6/25/24

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V 132	Continued From page 1 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 record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are: Review on 5/28/24 of a police report dated 5/20/24 revealed: -The police officer from another city was dispatched on 5/20/24 at 9:31 pm. -"While speaking with [client #1's father] and [client #1], [the Licensee] called [client #1's father] on the telephone. [Client #1's father] told [the Licensee] he had located [client #1] and with [Name sergeant with other city's police department]. The phone was on speaker mode	V 132	I will assure that any allegation of abuse will be reported within 5 working days or less to the Health Care Personnel Registry. Notation of Day + time reported will be documented.	6-15-24

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V 132	Continued From page 2 so I was able to hear conversation. I could hear [the Licensee] state she located the vehicle at [address for restaurant in local city]. [The Licensee] then abruptly yelled at someone stating she could smell the alcohol on him before seeming to talk to a second person as she used a softer tone of voice to tell someone to go to the bathroom and come straight back..." Review of the North Carolina Incident Response Improvement System (IRIS) on 5/28/24 revealed: -There was no level III incident report submitted by the facility for the allegations of abuse (staff drinking alcohol while driving and staff driving reckless). Interview on 5/28/24 with client #1's father revealed: -On 5/20/24 he informed the Licensee, Former Staff (FS #2) left client #1 at a ice cream shop in another city. -The Licensee said she would look into the incident and get back with him. -The Licensee called and said she spoke with FS #2 over the telephone. -The Licensee said she thought FS #2 had a medical emergency. -The Licensee said FS #2's speech was slurred. -Around 10:30 pm the Licensee called back again and said she found FS #2 at a restaurant in the local city. -The Licensee said she could smell alcohol on FS #2. Interviews on 5/31/24 and 6/3/24 with the Licensee revealed: -She talked to the clients after the incident on 5/20/24. -Client #4 said FS #2 was "driving crazy" and said "[FS #2] was throwing something out of the	V 132		

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V 132	Continued From page 3 window." -The other clients didn't tell her anything. -When she saw FS #2 in the parking lot at the restaurant she did not smell alcohol on him. -She never said she smelled alcohol on FS #2 to anyone. -She did not get close enough to FS #2 to smell any alcohol on him the night of that incident on 5/20/24. -"Why would the police put that in his report." -The night of the incident, she checked the van and did not see any alcohol containers. -She didn't realize she should have reported the allegations to HCPR. -She confirmed the agency failed to report the allegations of abuse to HCPR within five working days.	V 132		
V 366	27G .0603 Incident Response Requirements 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;	V 366		

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V 366	Continued From page 4 (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 (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;	V 366		

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V 366	Continued From page 5 (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 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.	V 366		

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V 366	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement a policy governing their response to Level III incidents as required. The findings are: Review on 6/3/24 of an in-house incident report dated 5/20/24 revealed: -"On May 20, 2024 @approx 9:15 pm, received a call from [Client #1's father] and stated that he had received a phone call from [client #1] who is a resident at my facility Roshaun's House of Care and whose is his son. He stated that [client #1] said that he had been left at [Name of ice cream shop] in [Name of other city]...so I called [Former Staff (FS) #2] and ask where was he at with the residents, he stated that he was on the straight road, he said I'm going straight [Licensee]...I said to him I don't understand what you are saying [FS #2] and at that point he stated the same thing in addition to that he couldn't get explain but just that he was on the straight road. At that point I knew something was wrong, it sounded to me that he was having a medical emergency such as a stroke, I asked him to pull vehicle over to a place in which he could tell me where he was located, he did not do so, at this point I hung up phone with him and called 911...So at this point I called the facility call phone and [FS #2] answered, and I told him to put [client #4] on phone, once [client #4] was on the phone, I told him to please look for any street sign in which he was able to give me some type of location as to where they were located, at time he couldn't so I told him I do not want you to hang up I want you to stay with me on phone so you can try to give me location. So about 5-8 mins passed, and he	V 366	We will assure that the facility implement a policy governing our response to Level III incidents as required. We will report incident to IRIS. Develop and implement preventative measures not exceeding 45days from onset incident.	7/24

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V 366	Continued From page 7	V 366		

was able to give me landmark in which they were coming up on [Name of car dealership] [Name of restaurants]. I told [client #4] to tell [FS #2] to pull over vehicle took him a few minutes and [client #4] finally said that [FS #2] was pulling over... When I arrived, I made sure that all residents were safe, and then asked for [FS #2] to get out of the vehicle. In speaking with [FS #2] I asked why he out with the residents and what was he doing in [Name of other city], I could not make sense of what he was saying he was very disoriented and not himself. After questioning him for some time, [FS #2] left walking. I questioned residents as to what happened, why did they leave, they stated they wanted ice cream and [FS #2] took them to get it, but none of them had ice cream... No one stated specific answers to questions on this night of May 20, 2024. I called [Staff #1] to come and take over shift, he came to [Name of restaurant] where we were, I called a [Name of ride share company] to take resident's and [Staff #1] to facility..."

Review on 5/28/24 of a police report dated 5/20/24 revealed:
-The police officer from another city was dispatched on 5/20/24 at 9:31 pm.
-"While speaking with [client #1's father] and [client #1], [the Licensee] called [client #1's father] on the telephone. [Client #1's father] told [the Licensee] he had located [client #1] and with [Name Sergeant with other city's police department]. The phone was on speaker mode so I was able to hear conversation. I could hear [the Licensee] state she located the vehicle at [address for restaurant in local city]. [The Licensee] then abruptly yelled at someone stating she could smell the alcohol on him before seeming to talk to a second person as she used a softer tone of voice to tell someone to go to the

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V 366	Continued From page 8 bathroom and come straight back..." Review on 5/28/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There were no level III incident report submitted by the facility for the incident above. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 5/31/24 with the Licensee revealed: -She did an incident report for the portion of the incident when she got involved. -She did not put that incident into the IRIS system because it happened in the community and not at the facility. -"I thought I was only supposed to do an IRIS report if an incident occurred at the facility." -She confirmed the facility failed to implement a policy governing their response to Level III incidents as required.	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	V 367		

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V 367	Continued From page 9 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 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	V 367		

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V 367	Continued From page 10 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 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.	V 367		

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V 367	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 6/3/24 of an in-house incident report dated 5/20/24 revealed: -"On May 20, 2024 @approx 9:15 pm, received a call from [Client #1's father] and stated that he had received a phone call from [client #1] who is a resident at my facility Roshaun's House of Care and whose is his son. He stated that [client #1] said that he had been left at [Name of ice cream shop] in [Name of other city]...so I called [Former Staff (FS) #2] and ask where was he at with the residents, he stated that he was on the straight road, he said I'm going straight [Licensee]...I said to him I don't understand what you are saying [FS #2] and at that point he stated the same thing in addition to that he couldn't get explain but just that he was on the straight road. At that point I knew something was wrong, it sounded to me that he was having a medical emergency such as a stroke, I asked him to pull vehicle over to a place in which he could tell me where he was located, he did not do so, at this point I hung up phone with him and called 911...So at this point I called the facility call phone and [FS #2] answered, and I told him to put [client #4] on phone, once [client #4] was on the phone, I told him to please look for any street sign in which he was able to give me some type of location as to where they were located, at time he couldn't so I told him I do not want you to hang up I want you to stay with me on phone so you can try to give me location. So about 5-8 mins passed, and he	V 367	I will assure all incidents are reported to the Local Management Entity with 72hrs of becoming aware of the incident and will have Notation of Day & time of Notification will be documented.	7/25/24

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V 367	Continued From page 12 was able to give me landmark in which they were coming up on [Name of car dealership] [Name of restaurants]. I told [client #4] to tell [FS #2] to pull over vehicle took him a few minutes and [client #4] finally said that [FS #2] was pulling over... When I arrived, I made sure that all residents were safe, and then asked for [FS #2] to get out of the vehicle. In speaking with [FS #2] I asked why he out with the residents and what was he doing in [Name of other city], I could not make sense of what he was saying he was very disoriented and not himself. After questioning him for some time, [FS #2] left walking. I questioned residents as to what happened, why did they leave, they stated they wanted ice cream and [FS #2] took them to get it, but none of them had ice cream... No one stated specific answers to questions on this night of May 20, 2024. I called [Staff #1] to come and take over shift, he came to [Name of restaurant] where we were, I called a [Name of ride share company] to take resident's and [Staff #1] to facility..." Review on 5/28/24 of a police report dated 5/20/24 revealed: -The police officer from another city was dispatched on 5/20/24 at 9:31 pm. -"While speaking with [client #1's father] and [client #1], [the Licensee] called [client #1's father] on the telephone. [Client #1's father] told [the Licensee] he had located [client #1] and with [Name Sergeant with other city's police department]. The phone was on speaker mode so I was able to hear conversation. I could hear [the Licensee] state she located the vehicle at [address for restaurant in local city]. [The Licensee] then abruptly yelled at someone stating she could smell the alcohol on him before seeming to talk to a second person as she used a softer tone of voice to tell someone to go to the	V 367		

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V 367	Continued From page 13 bathroom and come straight back..." Review on 5/28/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There were no level III incident report submitted by the facility for the incident above. Interview on 5/31/24 with the Licensee revealed: -She did an incident report for the portion of the incident when she got involved. -She did not put that incident into the IRIS system because it happened in the community and not at the facility. -"I thought I was only supposed to do an IRIS report if an incident occurred at the facility." -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours.	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.	V 500		

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V 500	Continued From page 14 (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 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	V 500		

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V 500	Continued From page 15 over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS). The findings are: Review on 5/28/24 of a police report dated 5/20/24 revealed: -The police officer from another city was dispatched on 5/20/24 at 9:31 pm. -"While speaking with [client #1's father] and [client #1], [the Licensee] called [client #1's father] on the telephone. [Client #1's father] told [the Licensee] he had located [client #1] and with [Name Sergeant with other city's police department]. The phone was on speaker mode so I was able to hear conversation. I could hear [the Licensee] state she located the vehicle at [address for restaurant in local city]. [The Licensee] then abruptly yelled at someone stating she could smell the alcohol on him before seeming to talk to a second person as she used a softer tone of voice to tell someone to go to the bathroom and come straight back..." Review of the North Carolina Incident Response Improvement System (IRIS) on 5/28/24 revealed: -There was no level III incident report submitted by the facility for the allegations of abuse (staff drinking alcohol while driving and staff driving reckless). -There was no indication DSS was contacted about the above allegation of abuse. Interview on 5/28/24 with client #1's father	V 500	I will assure that any allegation of abuse be reported to the Department of Social Services, and notation of day + time will be documented. 7/25/24	

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V 500	Continued From page 16 revealed: -On 5/20/24 he informed the Licensee, Former Staff (FS#2) left client #1 at a ice cream shop in another city. -The Licensee said she would look into the incident and get back with him. -The Licensee called and said she spoke with FS #2 over the telephone. -The Licensee said she thought FS #2 had a medical emergency. -The Licensee said FS #2's speech was slurred. -Around 10:30 pm the Licensee called back again and said she found FS #2 at a restaurant in the local city. -The Licensee said she could smell alcohol on FS #2. Interviews on 5/31/24 and 6/3/24 with the Licensee revealed: -She talked to the clients after the incident on 5/20/24. -Client #4 said FS #2 was "driving crazy" and said "[FS #2] was throwing something out of the window." -The other clients didn't tell her anything. -When she saw FS #2 in the parking lot at the restaurant she did not smell alcohol on him. -She never said she smelled alcohol on FS #2 to anyone. -She did not get close enough to FS #2 to smell any alcohol on him the night of that incident on 5/20/24. -"Why would the police put that in his report." -The night of the incident, she checked the van and did not see any alcohol containers. -She didn't realize she should have reported the allegations to DSS. -She confirmed the agency failed to report the allegation of abuse to DSS.	V 500		

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V 512	Continued From page 17	V 512		
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. This Rule is not met as evidenced by: Based on record reviews and interviews, one of one audited former staff (FS #2) neglected five of five clients (#1, #2, #3, #4 and #5). The findings are: Review on 5/29/24 of the personnel record for FS #2 revealed: -Date of hire was 10/4/22.	V 512	All staff has been trained on Client Abuse Neglect & exploitation, 7/24/24	

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V 512	Continued From page 18 -Hired as a Care Giver. -He was terminated on 5/20/24. Review on 5/29/24 of client #1's record revealed: -Admission date of 5/11/15. -Diagnoses of Anoxia Brain Injury, Bipolar Disorder, Seizure Disorder, Attention Deficit Hyperactivity Disorder, Chronic Lower Back Pain and Gastroesophageal Reflux Disease. Review on 5/29/24 of client #2's record revealed: -Admission date of 9/6/12. -Diagnoses of Schizophrenia, History of Substance Abuse and Tobacco Dependence. Review on 5/29/24 of client #3's record revealed: -Admission date of 1/7/23. -Diagnoses of Autism Spectrum Disorder and Major Depressive Disorder. Review on 5/29/24 of client #4's record revealed: -Admission date of 7/8/21. -Diagnosis of Schizophrenia. Review on 5/29/24 of client #5's record revealed: -Admission date of 10/20/22. -Diagnosis of Schizophrenia. Review on 6/3/24 of an in-house incident report dated 5/20/24 revealed: -"On May 20, 2024 @ approximately (approx) 9:15 pm, received a call from [Client #1's father] and stated that he had received a phone call from [client #1] who is a resident at my facility Roshaun's House of Care and whose is his son. He stated that [client #1] said that he had been left at [Name of ice cream shop (15 miles from facility)] in [Name of other city]...so I called [FS #2] and ask where was he at with the residents, he stated that he was on the straight road, he	V 512		

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V 512	Continued From page 19 said I'm going straight [Licensee]...I said to him I don't understand what you are saying [FS #2] and at that point he stated the same thing in addition to that he couldn't get explain but just that he was on the straight road. At that point I knew something was wrong, it sounded to me that he was having a medical emergency such as a stroke, I asked him to pull vehicle over to a place in which he could tell me where he was located, he did not do so, at this point I hung up phone with him and called 911...So at this point I called the facility call phone and [FS #2] answered, and I told him to put [client #4] on phone, once [client #4] was on the phone, I told him to please look for any street sign in which he was able to give me some type of location as to where they were located, at time he couldn't so I told him I do not want you to hang up I want you to stay with me on phone so you can try to give me location. So about 5-8 minutes (mins) passed, and he was able to give me landmark in which they were coming up on [Name of car dealership] [Name of restaurants]. I told [client #4] to tell [FS #2] to pull over vehicle took him a few minutes and [client #4] finally said that [FS #2] was pulling over... When I arrived, I made sure that all residents were safe, and then asked for [FS #2] to get out of the vehicle. In speaking with [FS #2] I asked why he out with the residents and what was he doing in [Name of other city], I could not make sense of what he was saying he was very disoriented and not himself. After questioning him for some time, [FS #2] left walking. I questioned residents as to what happened, why did they leave, they stated they wanted ice cream and [FS #2] took them to get it, but none of them had ice cream... No one stated specific answers to questions on this night of May 20, 2024. I called [Staff #1] to come and take over shift, he came to [Name of restaurant] where we were, I called a	V 512		

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V 512	Continued From page 20 [Name of ride share company] to take resident's and [Staff #1] to facility..." Review on 5/28/24 of a police report dated 5/20/24 revealed: -The police officer from another city was dispatched on 5/20/24 at 9:31 pm. -"While speaking with [client #1's father] and [client #1], [the Licensee] called [client #1's father] on the telephone. [Client #1's father] told [the Licensee] he had located [client #1] and with [Name Sergeant with other city's police department]. The phone was on speaker mode so I was able to hear conversation. I could hear [the Licensee] state she located the vehicle at [address for restaurant in local city]. [The Licensee] then abruptly yelled at someone stating she could smell the alcohol on him before seeming to talk to a second person as she used a softer tone of voice to tell someone to go to the bathroom and come straight back..." Interview on 5/30/24 with client #1 revealed: -There was an incident on 5/20/24 with FS #2. -FS #2 asked if they (clients) wanted to go out and get ice cream. -They left the facility around 4:45 pm. -They stopped by the other facility and stayed there for about 15-20 minutes. -They then stopped by the Alcohol Beverage Control (ABC) store and was there for about 5-8 minutes. -When they were at the ABC store FS #2 came back to the van with a bag "full of liquor." -There were "4-5 pint sized" bottles of alcohol in the bag. -They also stopped at someone's house and FS #2 went inside and stayed for 10 minutes. -All 5 of them stayed on the van unsupervised whenever FS #2 stopped at those places in the	V 512		

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V 512	Continued From page 21 local city. -FS #2 was speeding and going in and out of lanes the entire time he was driving the van. -People in other vehicles were beeping their horns at FS #2. -He was "afraid of the way" FS #2 was driving. -He thought "[FS #2] was going to wreck the van." -"[FS #2] drank 1-2 bottles of the alcohol while he was driving the van." -He thought FS #2 was also "high" because of the way he was driving. -When they arrived in the other city it was close to 8:00 pm. -FS #2 drove by the ice cream place twice because he was driving "too" fast. -FS #2 had to circle the block twice and hit a plastic crosswalk sign. -"[FS #2] parked the van in a bike lane and he and I got off the van." -The other 4 clients stayed on the van unsupervised. -They went into the ice cream shop and FS #2 ordered ice cream for all 5 of them. -FS #2 said he needed to move the van because it was parked in the bike lane. -FS #2 told the guy working in the ice cream shop that he would be back and "watch my client." -FS #2 left him in the ice cream shop and walked back to the van. -FS #2 drove away and left him in the ice cream shop. -He waited about 15 minutes because he thought FS #2 was just circling the block. -He walked outside and waited another 15 minutes and saw the van from a distance with the flashers on. -He thought FS #2 was coming back to pick him up. -He saw the van take off and go in the opposite direction.	V 512		

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V 512	Continued From page 22 -"I said to myself, why did he leave me." -He went back into the ice cream shop and ate his ice cream and sat there about another 10 minutes. -It was close to 9:00 pm and already dark outside. -He called his father and reported FS #2 "left me abandoned" at a ice cream shop in another city. -He had been at the ice cream shop about 45 minutes before he called his father. -A police officer from the other city picked him up from the ice cream shop and took him to the police department. -His father met him at the police department and he went home with his father. Attempt to interview client #2 on 5/30/24 revealed: -He could not be interviewed because his responses were not related to questions. Interview on 5/29/24 with client #3 revealed: -Last week they (clients) went to get ice cream in another city and FS #2 left client #1 in that other city. -Prior to driving to the other city FS #2 stopped a few places. -FS #2 stopped at someone's house and stayed inside for about 30 minutes. All 5 of them remained on the van unsupervised. -FS #2 stopped at a store and stayed in there for about 30 minutes, they all stayed on the van unsupervised. -FS #2 also stopped at the ABC store in the local city and was only in there for about 5 minutes. All of them stayed on the van unsupervised. -FC #2 came back to the van with a paper bag after he walked out of the ABC store. -He saw FS #2 drink 2 small glass bottles of alcohol while driving the van. -FS #2 threw the empty bottles out the window of	V 512		

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V 512	Continued From page 23 the van after he drank them. -They were on the highway headed to the other city when FS #2 was drinking alcohol and threw the empty bottles out the window. -They made it to the ice cream shop in the other city and only FS #2 and client #1 got out of the van. -FS #2 and client #1 walked into the ice cream shop. -About 20 minutes later FS #2 walked back to the van and client #1 was not with him. -He asked where client #1 was and FS #2 "ignored me." -FS #2 left the ice cream shop and headed back to the local city. -It was close to 9:00 pm when they left the ice cream shop, it was dark outside. -When FS #2 was driving back to the local city he was driving "dangerously." -He was "scared" because FS #2 was driving on the wrong side of the road and other people were blowing their horns at them. -"I thought we were going to get hit." -The Licensee called FS #2's phone and told him to pull the van over. -FS #2 pulled over at a restaurant in the local city. -The Licensee talked to FS #2 when she arrived to the restaurant. -FS #2 walked away from the parking lot a few minutes later. -Staff #1 met them at the restaurant and they rode back to the facility in a ride share vehicle. -"We didn't get our ice cream after going through all of that." Interview on 5/29/24 with client #4 revealed: -Last Monday (5/20/24) FS #2 asked if they (clients) wanted to go out and get ice cream. -They left the facility and made a few stops on their way to the other city.	V 512		

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V 512	Continued From page 24 -They stopped at someone's house. -All 5 of them stayed in the van unsupervised for about 30 minutes while FS #2 was in that person's house. -FS #2 also stopped at the liquor store and stayed in there about 5 minutes. -They stayed on the van unsupervised while FS #2 was in the liquor store. -He wasn't sure what he brought from the liquor store. -He didn't see anything in FS #2's hands when he returned to the van. -He never saw FS #2 drinking alcohol while he was driving the van. -FS #2 drove them to the other city. -Client #1 and FS #2 got off the van, however he never saw them go into the ice cream shop. -He (client #4) and the other 3 clients stayed on the van. -About 30 minutes later FS #2 returned to the van and client #1 was not with him. -"It was dark at this point" and some of them asked where client #1 was and FS #2 didn't say anything. -They didn't get any ice cream. -FS #2 got into the van and drove away. -Client #1 had an issue with his leg and walking. -"[FS#2] shouldn't have left [client #1] by himself." -When FS #2 was driving back to the local city he was "driving erratic." -FS #2 was "swerving and sometimes driving on the wrong side of the highway." -It was dark outside and they were "scared." -He thought they were going to get into an accident. -The Licensee called him (client #4) on the phone and told FS #2 he needed to pull over. -FS #2 pulled over at a restaurant and "I took the keys from him because [the Licensee] asked me to."	V 512		

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	MHL032-516	A. BUILDING: _____ B. WING _____	R-C 06/03/2024

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V 512	Continued From page 25 -"[FS #2] didn't seem like himself, I didn't know what was wrong with [FS #2]." Interview on 5/30/24 with client #5 revealed: -FS #2 took them (clients) out to get ice cream about a week ago (5/20/24). -They left the facility around 6:30 pm. -FS #2 stopped at another facility in the local city. -FS #2 stayed in that facility for about an hour. -All of them stayed on the van unsupervised while staff was in that other facility. -FS #2 also stopped at the ABC store in the local city and was in that store between 10-12 minutes. -All of them stayed on the van unsupervised while FS #2 was in the ABC store. -When FS #2 came out of the ABC store he had a paper bag with 3-4 small bottles of liquor in it. -FS #2 drank 3-4 bottles of alcohol while he drove to the other city. -FS #2 was speeding while he drove the van. -He was "afraid" of the way FS #2 was driving. -FS #2 was "speeding the entire time he drove the van." -When they arrived to the ice cream shop only FS #2 and client #1 got out of the van. -The rest of them stayed in the van unsupervised. -FS #2 and client #1 walked to the ice cream shop. -About 30-45 minutes later FS #2 came back to the van alone. -They all asked FS #2 why client #1 was not with him. -FS #2 didn't say anything and started the van and left. -He could not remember the exact time FS #2 returned to the van. -"It was dark outside at that point." -They rode around the other city for about 20 minutes. -They made it back to the local city and FS #2	V 512		

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V 512	Continued From page 26 pulled over to a restaurant. -The Licensee met them at the restaurant. -FS #2 walked away from the restaurant when the Licensee showed up. -They all rode back to the facility in a ride share vehicle. Attempted interviews on 5/30/24 and 5/31/24 with FS #2 revealed: -The original phone number provided for FS #2 was the work cell phone for the agency. -FS #2 did not answer the phone and a text message was sent to him requesting the call be returned. -FS #2 was called on his personal cell phone. -There was a message stating the person you are trying to reach was not accepting phone calls. -A text message was sent to FS #2 requesting the phone call be returned. -The phone call was never returned by FS #2 prior to the exit on 6/3/24. Interview on 5/29/24 with staff #1 revealed: -He got a phone call around 9:00 pm on 5/20/24 and the Licensee said she needed his help. -His girlfriend drove him around because he did not have a driver's license. -His girlfriend dropped him off at the restaurant. -The Licensee called a ride share vehicle and he rode with the clients back to the facility. -There were 4 clients with him in the ride share vehicle because client #1 was with his father. -He saw FS #2 in the parking lot at the restaurant. -He told FS #2, "you are better than this, we came here to better ourselves." -FS #2 looked "confused" and walked off. -He wasn't sure what was going on with FS #2. Interview on 5/28/24 with client #1's father revealed:	V 512		

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V 512	Continued From page 27 -Client #1 called around 9:00 pm on 5/20/24 and said FS #2 left him at a ice cream shop in another city. -He called 911 and asked to talk to the Watch Commander for the other city's police department. -The Watch Commander for the other city picked client #1 up from the ice cream shop and took him to the police station around 9:46 pm. -He tried to call FS #2, however she did not pick up. -He was able to get in contact with the Licensee. -He informed the Licensee FS #2 left client #1 at the ice cream shop in another city. -The Licensee said she would look into the incident and get back with him. -The Licensee called and said she spoke with FS #2 over the telephone. -The Licensee said she thought FS #2 had a medical emergency. -The Licensee said "[FS #2's] speech was slurred." -Around 10:30 pm the Licensee called back again and said she found FS #2 at a restaurant in the local city. -The Licensee said she could "smell alcohol on [FS #2]." Interviews on 5/29/24, 5/31/24 and 6/3/24 with the Licensee revealed: -On 5/20/24 there was an incident with FS #2. -Client #1's father called her initially and she didn't answer. -Client #1's father sent a text and she called him back. -She was informed by client #1's father that FS #2 left client #1 at the ice cream shop in another city unsupervised. -It was after 9:00 pm when she talked to client #1's father.	V 512		

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V 512	Continued From page 28 -She called FS #2 on the phone and asked why were they out so late. -She also asked FS #2 why did they drive all the way to another city for ice cream. -FS #2 wasn't making any sense when she talked to him. -"[FS #2's] speech was slurred, I thought he was having a stroke." -She asked FS #2 where was he and told him to pull the van over. -FS #2 was not able to tell her where they were. -She called 911 and reported the incident. -A few minutes later she called the facility cell phone and FS #2 answered it. -She told FS #2 to put client #4 on the phone. -Client #4 was able to tell her where they were. -She told client #4 to put the phone on speaker and she told FS #2 to pull the van over. -Client #4 said they were in the local city near a car dealership and a restaurant. -She knew where they were and drove over to that area. -FS #2 parked the van in the parking lot near the restaurant. -When she arrived FS #2 was in the van and the 4 clients were outside of the van. -FS #2 "did not look right, I thought he had a stroke." -She couldn't figure out what was wrong with FS #2. -She checked the van and did not see any alcohol containers. -She did not smell alcohol on FS #2 while he was in the parking lot. -FS #2 never gave her an explanation as to why he left client #1 at the ice cream shop. -FS #2 left the parking lot on foot. -She had not seen or heard from FS #2 since that incident on 5/20/24. -She called a ride share and Staff #1 met her at	V 512		

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V 512	Continued From page 29 the restaurant. -Staff #1 rode back to the facility with the clients. -She thought it was around 10:45 pm when they left the restaurant. -Police Officers from the local police department showed up around 11:00 pm. -FS #2 had already left when the police officers showed up. -She talked to the clients after the incident on 5/20/24. -Client #4 said FS #2 was "driving crazy" and said "[FS #2] was throwing something out of the window." -The other clients didn't tell her anything. -FS #2 was terminated the same night of that incident on 5/20/24. Review on 6/3/24 of a Plan of Protection written by the Licensee dated 6/3/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? [Staff #2] was terminated on onset date of May 20, 2024. Other staff will be trained on protection, harm. neglect, and exploitation of residents. A curfew for time out with residents will be put in place. Describe your plans to make sure the above happens. Training will be completed by 6/14/24. [Qualified Professional]/[Licensee] will do quarterly interviews with residents/staff to assure that all persons are being kept in a safe environment." Clients diagnoses included Anoxia Brain Injury, Bipolar Disorder, Seizure Disorder, Attention Deficit Hyperactivity Disorder, Schizophrenia, Autism Spectrum Disorder, Major Depressive Disorder, History of Substance Abuse and Chronic Lower Back Pain. On 5/20/24, FS #2 took clients #1, #2, #3, #4, and #5 on a community outing and made several stops during	V 512		

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V 512	Continued From page 30 which FS #2 left the 5 clients unsupervised in the van between 5 minutes to one hour. During one stop, FS #2 purchased several small bottles of alcohol at a local ABC Store. FS #2 then consumed the alcohol while driving with the clients in the van. FS #2 drove in a manner where he swerved and switched lanes erratically which caused fear amongst the clients. At a local ice cream shop, FS #2 left client #1 alone and unsupervised having driven off in the van with clients #2-#5. The Licensee was unable to ensure the safety of the clients based upon FS #2's alcohol consumption and actions and relied upon client #4 to identify the location of the clients as well as secure the van keys once the vehicle was stopped. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. The findings are: Observation on 5/29/24 at approximately 11:40 AM revealed: -Kitchen area-the refrigerator door handle was broken.	V 736	I will assure facility grounds be maintained kept in a safe, clean, attractive, orderly manner & free from odor, will inspect monthly and notation of inspections will be documented	7/3/24

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V 736	Continued From page 31 -Clients #2 and #4's bedroom-A strong musty odor. There were approximately 10 items of clothing in a pile on the floor. Peeling paint on the bedroom door. -Bathroom in clients #2 and #4's bedroom-The blinds had two missing slats. Paint peeling on the walls. Grayish/brownish stain on the floor. Caulking substance on the wall. Black substance on wall behind the sink. -Client #5's bedroom-Blinds slat broken on the end. Walls had brownish/grayish stains. -Clients #1 and #3's bedroom-Peeling paint on walls. Interview on 5/29/24 with staff #1 revealed: -There was a leak in that bathroom about 3-4 months ago. -He thought that could be why the black substance was on the wall in the bathroom. -He was "constantly" telling the clients to clean the facility. -"I can't make them clean the home if they don't want to clean the home." -She confirmed the facility was not maintained in a safe, clean, attractive and orderly manner. Interview on 5/29/24 with the Supervisor In Charge revealed: -The Licensee was aware of some of the issues with the facility. -She confirmed the facility was not maintained in a safe, clean, attractive and orderly manner. This deficiency has been cited 3 time(s) since the original cite on 4/4/23 and must be corrected within 30 days.	V 736		