STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G003	A. BUILDING _____ B. WING _____	C 06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J. IVERSON RIDDLE DEVELOPMENTAL CENTER	300 ENOLA ROAD MORGANTON, NC 28655

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 6/26/24 for intake #NC00218545 and #NC00218776. The allegations were substantiated. In addition, a Condition of Participation in Client Protections was cited.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149); and ensure all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility neglected to ensure its policies and procedures that prohibit neglect and exploitation were implemented to protect 2 of 2 clients (#1 and #2). The finding is: Review of the facility's internal management investigation report dated 6/25/24 revealed on 6/19/24 at 5:53pm, staff A walked to the doorway	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 149	Continued From page 1	W 149		

of client #1's bedroom and opened the door. At that time, client #1 and client #2 were engaged in a sexual activity. Staff A was observed to walk away from the bedroom door, and walk down the hallway. Staff A returned at 5:55pm with Staff B and Staff C, and they entered client #1's bedroom. At 5:57pm, all three staff exited the bedroom. They put gloves on and Staff B and Staff C entered client #1's bedroom. At 5:59pm Staff A entered the bedroom.

Further review of the facility's management investigation report revealed that the facility concluded that there were no concerns regarding the incident being consensual and no evidence to suggest this was not an isolated event. While client #2 has 30 minute supervision checks, due to the target behavior leaving area without notice (LAWN), video review showed there was a late supervision check which resulted in a 3 minute lapse. According to the facility's management investigation, the late check resulted in residents being alone in the bedroom for only 3 minutes in contrast to potentially 15 minutes if the supervision check had occurred on time. The management investigation concluded with no further concerns regarding clients' supervision in the home.

Review on 6/26/24 of the facility's video surveillance footage from 6/19/24 revealed at 5:07pm, staff completed a supervision check on client #2. At 5:51pm, client #1 entered his bedroom with client #2, closing the bedroom door behind them. At 5:53pm, Staff A walks to the bedroom door and opens it to complete 30 minute supervision checks, confirming a total of 46 minutes between checks, indicating a 16 minute lapse of time with client #2's supervision

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W 149	Continued From page 2	W 149		

checks.

Continued review of the video surveillance from 6/19/24 revealed at 5:54pm, Staff A closes the bedroom door and walks down the hallway. At 5:55pm, Staff A returns with Staff B and Staff C. At 5:58pm, the three staff enter the bedroom, then exit the bedroom, closing the door behind them while leaving client #1 and client #2 in the bedroom alone. At 6:10pm, Staff A returns to check on the client, revealing 12 minutes leaving the clients alone and a total of 18 minutes of staff knowing the clients were alone.

Review of record and interviews revealed at the time staff entered the bedroom at 5:53pm, client #2 was laying across the bed, feet on the floor, with his pants down. Client #1 was behind client #2, with his pants down. Staff A attempted to verbally redirect the clients without success. Staff A, B and C further attempted to verbally redirect the clients without success, leading Staff A, B and C to physically prompt the clients to stop.

Review on 6/26/24 of client #1's behavior support program (BSP) dated 1/2/19, 1/30/20, 2/2/21 and 12/6/21 revealed "[Client #1's] time with other residents needs to be monitored given the possibility of exploitation and the incidence of several residents making false allegations towards one another. If inside, staff needs to do visual checks every 15 minutes if he leaves staff responsible for his group, being mindful to monitor interactions with residents he has conflict with."

Further interviews and review of records produced by the facility revealed the facility put safeguards in place including placing client #1 on

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W 149	Continued From page 3 1:1 supervision until a lock could be placed on the bathroom door that adjoins client #1 and client #2's bedrooms, as well as alarms on the bedroom doors. Interview on 6/26/24 with the qualified intellectual disabilities professional (QIDP) revealed there have been issues in the past with client #1 asking his peers to "do things," i.e. sexual inappropriate behaviors. Interview on 6/26/24 with the director of psychology revealed he has no knowledge of client #1 having inappropriate sexual behaviors, as he does not know what the definition of that term is. Therefore, it would not be a part of client #1's BSP. Interview on 6/26/24 with the director of advocacy and director of quality improvement revealed an advocacy investigation was not opened at the time of the incident as there were no concerns of neglect. However, they did an "inquiry" into the incident, and concluded there were no concerns regarding the late supervision check, as it was a "flawed" service, meaning it was provided but late. Interview on 6/26/24 with the assistant facility director revealed that client #1's BSP referencing exploiting his peers she thought meant he will make false allegations. Continued interview revealed the management investigation concluded that the late supervision check was a positive thing, as it left the clients alone for less time than had the supervision check been done on time. In addition, the incident appeared to be consensual in nature.	W 149		

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W 149	Continued From page 4 Review on 6/26/24 of the facility's policy "Philosophy on Sexuality" revealed "As all members in our society, persons with developmental disabilities needs to learn to defer sexual gratification, how to exercise their rights to sexual expression in a way which will not be embarrassing to themselves or others, which will not infringe on the right of others, or which will not interfere with that individual's own responsibilities." Review of client records revealed there was no guardian consent informing them of the clients desire to be sexually active and the approval of the potential consequences of harm from "isolated events" with peers, in their home, or with others on campus, since both clients are adjudicated incompetent. Review on 6/26/24 of the facility's internal policy "Protecting Residents from Rights Infringements," dated 3/19/21, revealed neglect as being defined as "failure to provide or services necessary to maintain the mental and physical health of the resident." Based on review of records, video surveillance and interviews, the facility neglected clients #1 and #2 by failing to adequately supervise the clients given client #2's 30 minute LAWN checks and client #1's history of exploiting other clients including as per interview, sexually inappropriate behaviors.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 5 This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to thoroughly investigate allegations of neglect and exploitation for 2 of 2 audit clients (#1 and #2). The finding is: Review of the facility's internal management investigation report dated 6/25/24 revealed on 6/19/24 at 5:53pm, staff A walked to the doorway of client #1's bedroom and opened the door. At that time, client #1 and client #2 were engaged in a sexual activity. Staff A was observed to walk away from the bedroom door, and walked down the hallway. Staff A returned at 5:55pm with Staff B and Staff C, and they entered client #1's bedroom. At 5:57pm, all three staff exited the bedroom. They put gloves on and Staff B and Staff C enter client #1's bedroom. At 5:59pm Staff A enters the bedroom. Further review of the facility's management investigation report revealed that the facility concluded that there were no concerns regarding the incident being consensual and no evidence to suggest this was not an isolated event. While client #2 has 30 minute supervision checks, due to the target behavior leaving area without notice (LAWN), video review showed there was a late supervision check which resulted in a 3 minute lapse. According to the facility's management investigation, the late check resulted in residents being alone in the bedroom for only 3 minutes in contrast to potentially 15 minutes if the supervision check had occurred on time. The management investigation concluded with no further concerns regarding clients' supervision in the home. Review on 6/26/24 of the facility's video	W 154		

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surveillance footage from 6/19/24 revealed at 5:07pm, staff completed a supervision check on client #2. At 5:51pm, client #1 entered his bedroom with client #2, closing the bedroom door behind them. At 5:53pm, Staff A walks to the bedroom door and opens it to complete 30 minute supervision checks, confirming a total of 46 minutes between checks, indicating a 16 minute lapse of time with client #2's supervision check.

Continued review of the video surveillance from 6/19/24 revealed at 5:54pm, Staff A closes the bedroom door and walks down the hallway. At 5:55pm, Staff A returns with Staff B and Staff C. At 5:58pm, the three staff enter the bedroom, then exit the bedroom, closing the door behind them while leaving client #1 and client #2 in the bedroom alone. At 6:10pm, Staff A returns to check on the client, revealing a total of 12 minutes leaving the two clients alone.

Review on 6/26/24 of client #1's behavior support programs (BSPs) dated 1/2/19, 1/30/20, 2/2/21 and 12/6/21 revealed "[Client #1's] time with other residents needs to be monitored given the possibility of exploitation and the incidence of several residents making false allegations towards one another. If inside, staff needs to do visual checks every 15 minutes if he leaves staff responsible for his group, being mindful to monitor interactions with residents he has conflict with."

Interview on 6/26/24 with the qualified intellectual disabilities professional (QIDP) revealed there have been issues in the past with client #1 asking his peers to "do things," i.e. sexual inappropriate behaviors.

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W 154	Continued From page 7 Interview on 6/26/24 with the director of advocacy and director of quality improvement revealed an advocacy investigation was not opened at the time of the incident as there were no concerns of neglect. However, they did an "inquiry" into the incident, and concluded there were no concerns regarding the late supervision check, as it was a "flawed" service, meaning it was provided but was late. The director of advocacy confirmed that review of video surveillance footage was not done after the staff left the room, not realizing the clients continued to be left alone. Interview on 6/26/24 with the assistant facility director revealed that client #1's BSP referencing exploiting his peers she thought meant he will make false allegations. Continued interview revealed the management investigation concluded that the late supervision check was a positive thing, as it left the clients alone for less time than had the supervision check been done on time. In addition, the incident appeared to be consensual in nature. Review on 6/26/24 of the policy "Reporting Abuse, Neglect and Exploitation in DHHS" revealed "all allegations of abuse, neglect or exploitation shall be investigated and otherwise dealt with in accordance to the facility's internal policy." Based on review of records, video surveillance and interviews, the findings indicate that the facility failed to thoroughly investigate the incident when neglect and exploitation were in question due to a lack of supervisoin by staff.	W 154		