STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080096	A. BUILDING: ______ B. WING ______	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD	609 NEWSOME ROAD SALISBURY, NC 28144

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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 survey was completed on 6/28/24. One complaint was substantiated (intake #NC218260) and the other was unsubstantiated (intake #NC218272). A deficiency was 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 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients. This facility is located next door to a sister facility (residential facility) and there is another sister facility (day program). The sister facilities will be identified as sister facility A (residential facility) and sister facility B (day program). Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000	V 512 RHA Health Services will ensure all employees protect all clients from harm, abuse, neglect and exploitation. RHA will hold a mandatory House Meeting with the Brentwood DSP and Clinical team members on 6/28/2024 and complete in-service training regarding reporting abuse, neglect and exploitation and the Abuse Investigation process as listed: The Administrator will ensure all steps are followed once an allegation of abuse, neglect or exploitation is reported to include the following steps: 1) Immediate suspension of the staff alleged to have committed the abuse. 2) Instruct the Human Resources (HR) Specialist to suspend the accused staff in Workday. 3) Inform the accused staff of the allegations against them. 4) Instruct the accused staff they are not allowed on RHA property or premises.	7/16/2024
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	5) De-brief the Investigation Team of the allegations. The Qualified Professional will in-service the DSP staff on completing the Shift Exchange Responsibilities and reviewing RHA HR Policy 420 which includes policies and procedures on reporting and inappropriate staff behavior which includes refraining from sleeping while on RHA property. The Administrator will confirm a complete review of recent investigations is completed to ensure the following items were completed: 1) Confirm in Workday the accused staff was placed on suspension during investigation. 2) Follow up with the Investigation Team regarding the process of flow of the investigation. 3) QP will obtain Shift Exchange forms to ensure shift changes were completed. 4) QP will verify time and clock in/out	

attendance is reviewed and approved weekly. The QP will schedule a meeting with the people supported in the facility each month and review definitions of abuse, neglect & exploitation to include how and who to notify if they need to report an allegation or immediate safety concern in the facility to include a list of contact and on-call phone numbers of the Clinical team members. The Administrator will require all QP and other appropriate Clinical staff are re-trained on the entire Investigation process by the Director of Quality Assurance on 7/17/2024. These items will be monitored by the Clinical team members (QP, Direct Support Supervisor, Vocational Program Manager and Administrator) who will complete at minimum two (2) Interaction Assessments, will conduct the Rights Assessment at least 1x per week to ensure that the members can report if they feel safe, and unannounced visits to the facility two times per week for four (4) weeks and then on an ongoing 1x weekly basis. The QP will ensure all DSP staff are in-service trained on reporting Abuse, Neglect & Exploitation, HR Policy 420 and Shift Exchange procedures in the facility. The Administrator will ensure the Investigation process is followed appropriately and timely when an allegation is made towards any RHA staff member. The VP of Operations will approve all Investigations to ensure a thorough and complete investigation and conclusions are completed for any allegation of abuse, neglect and exploitation

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KC Hampton	IDD Administrator	7/16/2024

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V 512	Continued From page 1 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, interviews, and observations, 1 of 3 audited staff (staff A1) abused and harmed 1 of 3 clients (client #1) and 1 of 3 audited staff (staff #2) neglected 2 of 3 clients (#1 and #2). The findings are: Review on 6/21/24 of staff A1's personnel record revealed: - Hire date: 11/14/22. - Job Title: Residential Team Lead. - Met the qualifications as a Paraprofessional. Review on 6/21/24 of staff #2's personnel record revealed: - Hire date: 10/12/23. - Job Title: Direct Support Professional. - Met the qualifications as a Paraprofessional. Review on 6/21/24 of client #1's record revealed: - Admission date: 2/27/09. - Diagnoses: Moderate Intellectual Disabilities; Bipolar Disorder; Obsessive Compulsive Disorder; and Intermittent Explosive Disorder. - No documentation in client #1's record that indicated he could have unsupervised time. Review on 6/21/24 of client #2's record revealed:	V 512		

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Continued From page 2

- Admission date: 4/13/24.
- Diagnoses: Mild Intellectual Disabilities; Anxiety Disorder; Autistic Disorder; and Oppositional Defiant Disorder.
- No documentation in client #2's record that indicated he could have unsupervised time.

Finding #1

Review on 6/19/24 of the Incident Response Improvement System (IRIS) revealed:
- Date of Incident: 6/5/24
- Name of Supervisor Authorizing Report: Administrator/Qualified Professional (QP)
- "On 06/05/24, [client #1] made an allegation that [staff A1] choked him and held him down using her knees."
- "6/20/24 Provider will like to re-open this case due additional information provided ..."
- Initial Internal investigation was completed on 6/10/24 and was unsubstantiated for physical abuse.
- A second internal investigation was completed on 6/25/24 and was substantiated for physical abuse.

Review on 6/20/24 of pictures taken by Nurse #2 dated 6/6/24 at 11:17 am revealed:
- A large linear purple/red bruise across client #1's shoulder blade along with other bruising below the linear purple/red bruise.

Interviews on 6/24/24 and 6/27/24 with Nurse B2 revealed:
- She was a Licensed Practical Nurse.
- Client #1 came into the nurse's office on 6/6/24 at the day program.
- Client #1 told her that his back hurt and he needed over the counter pain medication. - Client #1 pulled up his shirt and that was when

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she saw the bruising to his right shoulder and took pictures.
- "[Client #1] told me he was pushed up against the wall by [staff A1]. [Client #1] said [staff A1] grabbed his neck and then pushed him up against the wall."
- She did not look at client #1's neck on 6/6/24 and she did not take a picture of client #1's neck. - She showed the administrator/QP client #2's back.
- She completed an incident report "and turned it over to the [Administrator/QP]."

Observations and Interview on 6/20/24 at approximately 11:36 am-11:49 am with client #1 revealed:
- He did not feel safe in his facility.
- He recalled that on 6/5/24 client #2 was outside and staff #2 told client #2 to go next door. - When he, staff A1 and staff #2 were the facility, staff A1 "put me on my stomach and had her knee on my back ...and choked me."
- "I could not breathe and told her (staff A1) I can't get up."
- He did not know why staff A1 had her knee on his back and choked him.
- "Staff #2 was the staff who told staff A1 to do it
(choke and put her knee on his back)."
- At some point during the 6/5/24 incident he got up and went outside.
- During the 6/5/24 incident staff A1 threw his shoes away and he did not know why she did this. - He pointed to the right upper part of his back. "I had red/purple mark on my back."
- A nurse at the day program took a picture of his back. He did not recall any other marks or bruises on his back.
- He could not recall anything else that occurred that day.
-Observed client #1 rubbing his head and his

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hands together constantly. He was breathing heavily. Client #1 stated, he was "scared." - He further indicated he was "afraid" of staff A1.

Interviews on 6/20/24 and 6/25/24 with client #2 revealed:
- On 6/5/24, he, staff #2, and client #1 were at the park.
- When they were on their way home from the park, client #1 "got mad because [staff #2] wouldn't turn up the radio and play his song." - "[Client #1] started yelling in [staff #2's] ear and cussing. I don't like loud noises and I started to cry."
- Staff #2 pulled the van over and "all of us got out." Client #1 threw his lunch box in the middle of the road.
- When they arrived at the facility staff A1 was next door at the sister facility A.
- "[Staff #2] yelled out to [staff A1] who was on the front porch at the [sister facility A] to come over and 'clock [client #1's] a*s.' "
- Staff A1 told him to go over to the sister facility A. Then Staff #2, staff A1 and client #1 went into the facility.
- Staff #2 "slammed" the front door to the facility.
- "I walked slowly over to [the sister facility A] ...As I was walking, I heard screaming, cussing and a lot of racket inside the house. [Staff A1] was screaming and cussing and I heard [client #1] cuss." He never went inside the sister facility A. - Then he saw staff A1 come out of the facility with client #1's shoes and special Olympics calendar.
- "[Staff A1] was very angry."
- Staff A1 walked out of the front door of the facility then staff #2 came out followed by client #1.
- Staff A1 "threw the shoes and book into the front yard and went to pick up the book and tried to

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hand the book to [client #1]. When he (client #1) went to reach for the book, she pulled it back really fast and went to the driveway area and poured some type of liquid from a white Styrofoam cup onto the book."
- "I don't know why she (staff A1) did that she was mad. Every day she came in she was angry and had an attitude. The same with [staff #2]."
- After client #1 went outside he pulled off his top shirt and left his tank top on.
- " ...I saw a red handprint on his (client #1's) neck and a scratch across the front of his neck. He had a big purple and red mark on his right shoulder and the skin was off of it."
- Client #1 had no marks or bruises on him prior to going into the house. He knew this because when they were at the park earlier client #1 took off his outer shirt and he did not see any marks or bruises on him.
- "I don't even feel comfortable or safe with [staff #2] or [staff A1] on the property."
- "I have been stressed, scared and felt unsafe and having mental health problems" since the 6/5/24 incident.

Interview on 6/24/24 with staff #7 revealed:
- When she arrived on 2nd shift (3 pm) on 6/5/24 "I did not see anything happening."
- She did see client #1 without a shirt on "because he was hot and I saw marks on the front of his neck like nail marks and a bruise on his back on his right shoulder. The bruise was a nice size. The first day it was red and then the next it was black. I did do an incident report." - Client #1 told her staff A1 "attacked him" and had a "knee on his back" and "choked him" while he was on the ground.
- "[Client #1] did say [staff A1] threw his tennis shoes in the garbage can. He said she poured water in his coloring book."

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V 512	Continued From page 6 - On 6/5/24, she reported the incident to the Human Resource (HR) Specialist. She could not recall if the Administrator/QP was with the HR Specialist when it was reported. Interview on 6/24/24 with staff #3 revealed: - She worked 3rd shift on 6/5/24 and arrived around 10:00 pm. Client #1 was asleep but client #2 was awake. - When she came in staff #7 "told me [staff A1] threw [client #1's] shoes out of the house and [staff A1] poured water on some type of book of [client #1]." Staff #7 told her she had "turned in" the incident. - The next morning (6/6/24) when client #1 got up he came to her and showed her his back. - "From [client #1's] top right shoulder blade to almost the center of his back, about a foot long, the skin was taken off and there was bruising around it." She did not see any other marks. - Client #1 told her on 6/5/24, "[staff A1] grabbed him (client #1) by his throat and was choking him." Staff A1 and client #1 went from the living room down the hallway. "[Client #1] said she (staff A1) had her knee in his back and they were scuffling down the hallway. [Client #1] said [staff A1] had her knee in his back and only said that [staff #2] was helping [staff A1]." Client #1 did not provide details as to how staff #2 helped staff A1. "[Client #1] said that [staff A1] used a combine notebook (thick notebook with 3 rings) ...threw the notebook at his back." Interviews on 6/25/24 and 6/26/24 with staff #2 revealed: - On 6/5/24 she drove client #1 and client #2 from the park to the facility. - Client #1 wanted her to play a song and she told him she could not because she was driving. - Client #1 got upset and started having "his	V 512		

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V 512	Continued From page 7 behavior" and started yelling and screaming about "I don't like what you are playing and I don't like loud music." - After a while she pulled over because "he was showing his tail." She pulled into a nursing home parking lot that was down the road from the facility. - Client #1 got out of the van and threw his lunch box and ear pods into the road. She picked up the items and was able to get client #1 back into the van. - Around 2:45 pm they arrived back at the facility and saw staff A1 next door at the sister facility A's front porch. - "I got out of the van and threw my hands and said, 'I need help [client #1] is showing out.' " - Client #2 cried because client #1 had been yelling. She told client #1 to go next door (sister facility A) because he "was upset." - Client #1 walked into the facility and "slung his book bag on the couch and walked back to his room and slammed his door open. His door hit the wall." Client #1 was yelling that he did not want to be there. - Client #1 went out to the hallway and was trying to move the washer and dryer. - Around 2:50 pm she walked outside to work on her notes. - "[Staff A1] was by herself with [client #1] inside of the house. About 2-3 minutes later [staff A1] walked outside with a book and it was one of [client #1's] books." - While client #1 was inside by himself with staff A1 he yelled that he didn't want staff A1 as his staff and called staff A1 "the B word and he hated her." - "I don't know what she (staff A1) did with the book." - Denied that staff A1 had any other items of client #1. "I didn't see [staff A1] have no shoes."	V 512		

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- Staff #7 pulled up to the facility while she was still on the porch.
- "When [staff A1] came out (the facility front door) with [client #1's] book [client #1] was right behind her. [Client #1] had on shorts and a short sleeve shirt that day. Sometimes he wears tank tops under his shirts."
- She did not see client #1 take off any shirts when he was outside.
- She did not see any marks, bruises or scratches on him.
- "I didn't know [client #1] had bruises on his back until the next day when the investigation stuff started. They asked if he fell at the park and I said 'no he didn't fall at the park.' "
- Denied that she and staff A1 had an altercation with client #1.
- Denied that she and staff A1 attempted to do any type of restraint with client #1.
- Denied that she and staff A1 choked client #1. - Denied that she and staff A1 got on client #1's back.
- "I did not put my hands on [client #1]."
- "I don't know how he (client #1) got bruises or scrapes."

Interview on 6/24/24 with staff A1 revealed: - On 6/5/24, she was sitting on the porch at the sister facility A when staff #2 pulled up in the van at the facility. Clients #1 and #2 were also in the van.
- She could hear "yelling" inside the van. - Staff #2 opened the van door and asked if she could come help her.
- Client #2 was crying and said he did not like the "yelling or screaming." She told client #2 to go next door to sister facility A.
- She, staff #2 and client #1 went inside the facility.
- When client #1 went inside the facility he was

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"yelling, screaming and throwing his lunch bag around."
- She and staff #2 tried to get client #1 in his bedroom "to calm down." Client #1 went into his bedroom and was throwing "shoes and books" out of his bedroom into the hallway.
- "I grabbed the books and shoes and took them out on the front porch and threw them in the yard out of his reach." She threw client #1's personal items in the yard so that he could not throw the items at her and staff #2.
- "I threw them out in frustration."
- After she threw client #1's personal items outside "I never came back in the house." - Staff #2 came outside after her. Then client #2 came outside.
- Client #2 was screaming and yelling outside when staff #7 arrived to work her shift.
- When staff #7 arrived she and staff #2 told her
"what happened."
- Staff #7 took client #1 back inside the facility where he calmed down. She went back to the sister facility A to do a shift exchange and staff #2 had already left.
- She did not see any marks or bruises on client #1's back or neck on 6/5/24.
- " ...I did not touch him (client #1). I did not do anything that caused marks or bruises."

Interviews on 6/20/24, 6/21/24, 6/26/24 and 6/27/24 with the Administrator/QP revealed:
- She had been the QP for the facility since November/December 2023.
- She reopened the 6/5/24 internal investigation on 6/20/24. She reopened the internal investigation because she learned on 6/20/24 about the 6/6/24 pictures taken by nurse #2 of client #1's bruising on his back. She was not involved in the first internal investigation and will not be involved with the second internal

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investigation.
- On 6/5/24 she was with the HR` Specialist. Staff #7 called the HR Specialist to report an incident and she was present when the incident was being reported.
- On 6/5/24 staff #7 reported, "[client #1] said that [staff A1] choked him and held him down with her knee. I told her to do an incident report and have him seen by the nurse on the following day (6/6/24)."
- She suspended staff A1 on 6/5/24. - When the initial internal investigation was unsubstantiated on 6/10/24, "we made it where [staff A1] could not work at Brentwood (facility) but could work at other locations."
- The reopened internal investigation was substantiated for abuse by staff A1 on 6/24/24. Staff A1's employment was terminated.

Finding #2

Review on 6/20/24 of the IRIS revealed:
- Date of Incident: 6/18/24
- Name of Supervisor Authorizing Report: Administrator/QP
- "On 06/18/24, a member (client #2) called 911 stating that they were left alone at home for 1 hr (hour)."

Interview on 6/20/24 with client #2 revealed: - On 6/18/24 staff #2 took him and client #1 on an outing and returned to the facility.
- When they returned to the facility it was time for staff #2 to "clock out."
- "[Staff #2] just said 'bye have a great day see you tomorrow.' "
- He went back to his bedroom. Then he and client #1 talked in the living room and noticed there was no staff in the facility. - "That's when I started to panic ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD	609 NEWSOME ROAD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 11 - He called his mother and stayed on the phone with her while he went next door to the sister facility A. - "No one was next door." - He told his mother he was scared and she advised him to call 911. So he called 911. - Prior to the police arrival staff A8 and staff A9 returned to the sister facility A. - He went over to the sister facility A and asked staff A8 and staff A9 if staff #7 was with them. - "They (staff A8 and staff A9) said 'no.' I was panicking and told them I called the cops and my mom." - Staff A9 went over to staff #7's car and found her asleep. - "[Staff #7's] seat was all the way laid back and [staff A9] had to say her name twice before she woke up." - Staff #7's car was in the facility parking lot when staff #2 left. - The police arrived and he talked to the police officer. - Client #3 was not present when staff #2 left. - Client #3 got off his day program bus at the facility by the time staff A8 and A9 returned to the sister facility A. - He was unsure how long he had been left alone. "Maybe a hour or less." Interview on 6/20/24 with client #1 revealed: - He had been left alone recently but could not recall which staff member was working. - Could not recall any other information about the 6/18/24 incident. Interview on 6/20/24 with client #3 revealed: - On 6/18/24 he got off his day program bus at his facility around 3:30 pm. - The bus driver called his legal guardian because "no one was there."	V 512		

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V 512	Continued From page 12	V 512		

- When he walked up to the facility, he saw staff #7's car but did not see her.
- Client #2 "called the police."
- The staff who was supposed to be working, staff #7, was "in her car and was laying back and getting a little nap before her shift."
- He could not recall any further information about what occurred on 6/18/24.

Attempted Interview on 6/24/24 with local police officer:
- No return call.

Interview on 6/24/24 with Staff A8 revealed: - On 6/18/24, she and staff A9 returned to the sister facility A around 3:45 pm.
- When they got out of the van client #2 shouted over and said, "we have been here by ourselves for a hour."
- She asked client #2 where was staff #7 and client #2 said he did not know.
- Client #2 told her he had called his mother and the police.
- While she asked client #2 where was staff #7, staff A9 walked towards staff #7's car (located in the parking lot between both facilities).
- Staff A9 found staff #7 asleep in her car and told her to "wake-up." Staff #7 woke up but did not get out of her car. Staff #7 had her seat laying back. - She walked over to staff #7's car "and told her to get up." That was when staff #7 got out of her car.
- Then the police came.
- Staff #7 said that she came early to work to take a nap before her shift.

Interview on 6/24/24 with Staff A9 revealed: - On 6/18/24, she had seen staff #7's car parked in the parking lot and saw staff #2 on the porch when she clocked in at 2:56 pm.

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V 512	Continued From page 13 - On 6/18/24, she and staff A8 worked at the sister facility A. They left around 3:15 to pick up client A4 and returned to the sister facility A at 3:37 pm. - When they returned, clients #1 and #2 were over at the sister facility A. - Client #2 told her and staff A8 that they "were by themselves." Client #2 also told them he had called his mother and the police. - She went over to staff #7's car that was parked in the parking lot between the two facilities. - Staff #7 was asleep in her car with her seat down and her windows were down. - She stood beside staff #7's car door and called out her name twice, but staff #7 did not wake up. - Staff A8 walked up to staff #7's car and she walked off. Staff A8 called out her name and told staff #7 "to get up." At this point she was in the house and "I don't know when she got up." - The police came to the facility after they returned to the sister facility A. - She was unsure how long the clients had been left alone because when they went to pick up client A4 she was not sure if staff #2 was still there. Interview on 6/24/24 with Staff #7 revealed: - On 6/18/24 staff #2 worked 1st shift and she was scheduled for 2nd shift (3 pm). - On 6/18/24 she arrived around 1:45 pm. She rolled down her windows, leaned her seat back and took a nap. She did not clock in when she arrived at 1:45 pm. - When she pulled into the parking lot at 1:45 pm, staff #2 was outside on the ramp "so she (staff #2) knew I was there." - She was asleep in her car when staff #2 left. - "Staff next door (at sister facility A) I believe	V 512		

(woke me up)." Then she clocked in at 3:27 pm.
- "[Staff #2] left before I clocked in."

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- The police arrived and she was not charged.

Interviews on 6/25/24 and 6/26/24 with Staff #2 revealed:
- On 6/18/24 she worked 1st shift and left at 3:08 pm.
- Second shift (staff #7) was not in the facility when she left.
- "[Staff #7] pulled up early at 2:30 (pm). She just never got out of her car."
- "I am not going up to her car to tell her it is time to work. She knew she was at work."

Interviews on 6/19/24 and 6/27/24 with the Administrator/QP revealed:
- On 6/18/24 she received a telephone call from Staff A8 who told her that client #2 came over to the sister facility A. Client #2 reported that he and client #1 had been left alone. Client #2 reported he called his mother and the police. - None of the clients in the facility have unsupervised time in the community nor in the facility.
- On 6/18/24 staff #2 was supposed to be with the clients. Shift change was at 3:00 pm. - Client #3 was at his day program when the 6/18/24 incident occurred. She did not know what time client #3 got off the day program bus on 6/18/24.
- She talked to staff #7 who told her she had been asleep in her car on 6/18/24 when clients #1 and #2 were left alone. She talked to staff #7 about policy, procedures, clocking in on time and being ready for work.
- First shift was not to clock out until the second shift clocks in. "They know this, this is nothing new."
- The internal investigation was completed and staff #2 was terminated for leaving clients #1 and #2 alone.

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V 512	Continued From page 15 Review on 6/28/24 of the Plan of Protection dated 6/28/24 written by the Administrator/QP revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? All Clinicians and Staff members at the Brentwood home will be re-in serviced on reporting Abuse, Neglect, and Exploitation. Once an allegation is received, an investigation will be initiated with the following steps: Immediate suspension of the any allegation for the alleged staff. The Administrator will instruct Human Resource Specialist to suspend alleged staff in Workday. The Administrator will inform alleged staff regarding the allegations. The Administrator will instruct alleged staff they are not allowed on RHA (licensee) property or premises. The Administrator will brief the Investigation Team on the allegations. Qualified Professional will In-service staff regarding Shift Exchange responsibilities. Qualified Professional will In-service staff regarding Policies and Procedure regarding reporting to you. Describe your plans to make sure the above happens. A house meeting will be held on 6/28/2024 to review these policies. The team will complete a thorough review of the recent investigations to ensure: Administrator will confirm in Workday alleged staff is noted suspension. Administrator will follow up with Investigation Team regarding progress or flow of investigation. Qualified Professional will obtain verification forms to verify shift exchanges. Qualified Professional will verify time attendance and clock in attendance weekly."	V 512		

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The facility served client #1 and client #2 who had diagnoses of Mild Intellectual Disabilities, Anxiety Disorder, Autistic Disorder, Oppositional Defiant Disorder, Moderate Intellectual Disabilities, Bipolar Disorder, Obsessive Compulsive Disorder, and Intermittent Explosive Disorder. On 6/5/24 client #1 was having behavioral problems during an outing. When they returned from the outing staff #2 asked staff A1 to come over and help her. Client #1 was the only client who went into the facility with staff A1 and staff #2. Client #1 had no bruising or marks when he went into the facility. Client #2 was left outside. Once inside the facility, client #2 who was outside heard a lot of cussing and screaming by staff A1 and client #1. When client #1 came out of the facility he had a large bruise on his right shoulder blade, a red handprint and scratch across the front of his neck. Staff A1 and staff #2 could not provide any explanation for the marks and bruises found on client #1 right after he walked out of the facility. Staff A1 threw client #1's shoes and book out into the yard and poured water on his book. Client #1 reported to other staff that staff A1 held him down on the ground with her knee on his back and choked him. On 6/18/24 staff #2 left the facility at the end of her shift without doing a shift exchange and did not secure staff coverage for client #1 and client #2 before leaving the facility. Staff #7 was the next shift staff and had fallen asleep in her car before she was awakened by staff from the sister facility A. This left the clients unattended and unsupervised for approximately 30 minutes. Client #1 and Client #2 were frightened when they realized they were in the facility alone. Client #2 called his mother and 911 to report what had happened at the facility. This deficiency constitutes a Type A1 rule

V 512	Continued From page 17 violation for serious harm, abuse and neglect and must be corrected within 23 days.	V 512		