STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl001-073	A. BUILDING: _____ B. WING _____	09/17/2024

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L & J HOMES	803 ELIZABETH STREET BURLINGTON, NC 27217

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V 000	INITIAL COMMENTS An annual survey was completed on September 17, 2024. 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.	V 000		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

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V 512	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, one of four staff (#1) abused one of three clients (#1) and one of four staff (House Manager) failed to protect one of three clients (#1) from abuse. The findings are: Review on 9/11/24 of client #1's record revealed: -Admission date of 12/18/10. -Diagnoses of Schizoaffective Disorder - Depressed Type; Intellectual Developmental Disability - Mild; Hypothyroidism; Borderline Diabetes; History of Arnold-Chiari Malformation. Review on 9/11/24 of staff #1's personnel record revealed: -Date of hire was 1/3/20. -She was hired as a Direct Care Staff. Review on 9/11/24 of House Manager's personnel record revealed: -Date of hire was 5/22/14. Observation and interview on 9/12/24 at approximately 10:30 a.m. with client #1 revealed: -On 9/7/24, she wanted to go to the local agricultural festival being held in the park. -The owner asked if anyone wanted to go to the local restaurant or the local agricultural festival during a facility meeting with clients. -There was a vote and the clients voted to go to the local restaurant -Staff #1 took her to a thrift store. -She was not happy with staff #1 but didn't know why. -She and staff #1 returned to the facility. -She went to her bedroom and started yelling to staff #1, "Your mama's dead, your husband had	V 512		

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V 512	Continued From page 2 surgery and I hope he dies, hope your grandchildren die, well her whole family dies." -She called staff #1 a n****r. -Staff #1 came to her bedroom because she heard her hollering racial slurs. -She was sitting on her bed. -Staff #1 "patted" her on the mouth and face as a way of telling her to be quiet. -She demonstrated by tapping her mouth and each side of her face with her hand. -Staff #1 left her bedroom. -It was shift change and staff #3 reported to work. -She was still yelling and staff #1 returned to her bedroom and grabbed her by the hands. -Staff #1 "pulled" her out of her bedroom by holding her shirt and pushed her over the couch and told staff #3 to look. -Staff #1 pulled her hair upward on both sides. -She demonstrated by pulling the left and right sides of her hair upward with both hands. -It did hurt her when staff #1 pulled her hair. -Staff #3 intervened by stepping between client #1 and staff #1. -Staff #3 told staff #1 to let client #1 go. -It was staff #1's "first time ever doing this," and it was the first time she had called staff #1 racial slurs. -Client #2 was sitting in the living room during the incident and client #3 was in his bedroom. -She informed the House Manager of the incident on 9/11/24. Interview on 9/11/24 with client #2 revealed: -He was sitting in the living room when the incident occurred on 9/7/24. -He did not see staff #1 physically assault client #1. -He heard client #1 make racial slurs towards staff #1.	V 512		

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V 512	Continued From page 3 Interview on 9/11/24 with client #3 revealed: -He heard client #1 make racial slurs towards staff #1. -He was in his room when the incident occurred. Interview on 9/12/24 with staff #1 revealed: -Client #1 was quiet on the morning of 9/7/24 and wanted to go to a agricultural festival. -The clients have facility meetings every Saturday to voice any of their facility concerns and after the meeting they were asked if they wanted to go to a local restaurant or to an agricultural festival -Client #1 and client #3 wanted to go to the agricultural festival but were "outvoted." -The clients were taken to the local restaurant and client #1 began her behaviors. -Client #1 purchased a coffee and stated that she did not want it, then said that she wanted it after she (staff #1) offered it to another client. -She and client #1 got in the van and client #1 said that she was sorry. -Client #1 asked to go to a thrift store and "everything was okay." -She took client #1 to the thrift store of her choice. -She told client #1 that it was time to go back to the facility because it was time for her to take her medicine (2:00 pm medication). -Client #1 said that she was not going to take the medicine. -She and client #1 arrived at the facility and she asked her to take her medicine 3 times, 15 minutes apart, but client #1 refused. -Client #1 went to bed and went to sleep. -She began to prepare supper for the clients. -Client #2 and client #3 went to their bedrooms. -She asked client #1 to take her medicine. -Client #1 told her to bring her the medicine because it was her job.	V 512		

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V 512	Continued From page 4 -Client #1 came out of her bedroom and took her medicine. -Client #1 went back into her bedroom and to the bathroom. -She heard the toilet flush and client #1 came out and said she flushed the medicine. -She believed client #1 took the medicine when she initially administered it. -She walked though client #1's bedroom to go to the bathroom. -Client #1 threw trash on her bedroom floor because she did not want her to use her trash can. -She went back to the kitchen to prepare dinner. -While she was preparing dinner client #1 was agitated and yelled at her from her bedroom, "That's why your mom and daddy are dead." -Client #1 said she "hoped that my granddaughter and children die, and she hoped my n****r husband die." -She went into client #1's bedroom and asked how would she feel if those comments were made to her. -Client #1 said she "still had her mom and dad." -She closed client #1's bedroom door and client #1 continued to yell racial slurs. -The food was ready and she set the table. -She did not prepare client #1's food because client #1 said that she was not eating her food. -She cleaned the kitchen. -Client #1's bedroom door was still closed and she asked client #2 to knock on client #1's bedroom door and tell her to come eat. -She did not want to say anything to client #1 because she (staff #1) was "really mad." -Client #1 came out of her bedroom, ate, and went back to her bedroom. -Client #1 started to yell, "n****r die" continuously. -She went in client #1's bedroom and stood in front of her while client #1 sat on the bed.	V 512		

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V 512	Continued From page 5 -She told client #1 to "stop saying that and to say it again." -She assumed client #1 "heard the seriousness in her voice and saw the seriousness in her face." -She was "forceful with her facial expression and voice." -She left client #1's bedroom and closed the door. -She redirected client #1 throughout the incident. -She did not make any physical contact with client #1 at any time. -She worked with the agency for 4 years and with client #1 for one year. -It was the first time client #1 behaved that way with her. Observation and interview on 9/12/24 at approximately 12:10 p.m. with staff #2 revealed: -She arrived at the facility on 9/7/24 for second shift at 6pm. -Staff #1 sat at the kitchen table and the clients went to their bedrooms when they saw her. -Clients went to their rooms during shift change and while staff debriefed. -She observed staff #1's facial expression and asked what was wrong. -Staff #1 "gave her the history." - Client #1's - bedroom door was closed and she yelled the "N word." -Client #1 continuously called staff #1 a n****r from her bedroom. -She redirected client #1. -Client #1 would not stop yelling racial slurs and continued to call staff #1 a n****r. -Staff #1 got up from the kitchen table, went to client #1's room and told client #1 to "say it again." -She could see into client #1's bedroom from where she stood in the kitchen. -Client #1 was sitting on the bed. -Staff #1 "grabbed" client #1 by her dress and bra	V 512		

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V 512	Continued From page 6	V 512		

straps on her shoulder.
-Staff #1 "literally forced [client #1] out of bed."
-Staff #1 "dragged" client #1 to the living room near the love seat.
-Staff #1 "grabbed" the back of client #1's hair, while still holding her dress and bra straps, and said, "say it again."
-She intervened and stood between staff #1 and client #1.
-She physically separated staff #1's hands from client #1's hair, dress, and bra straps.
-Client #1 was "scared."
-Staff #1 left the facility and she went into client #1's bedroom.
-Client #1 said that she was mad because she wanted to go to the agricultural festival.
-Client #1 said that she told staff #1 she was mad and asked staff #1 to take her to the thrift store and other stores so that she could calm down.
-Client #1 said that she made racial slurs to staff #1.
-Client #1 said that staff #1 came to her bedroom and put her hand over her mouth.
-Client #1 demonstrated the way staff #1 placed her hand over her mouth.
-Staff #2 demonstrated by putting one hand over her mouth.
-Client #1 stated that it happened prior to her coming in to work.
-Client #1 did not have any marks or bruises.
-Client #1 did not report she was hurt.
-She checked client #1's scalp and did not observe any marks or bruises.
-She did not observe any marks or bruises anywhere on client #1.
-She informed the House Manager of the incident on 9/7/24.

Review on 9/11/24 of an in-house incident report written by staff #1 dated 9/7/24 revealed:

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V 512	Continued From page 7 -"After returning home from an outing, [client #1] was allowed to choose, she was still agitated and refused 2pm meds. Staff offered medication three times, 15 minutes apart, refused each time and went to sleep. When she woke up, she begin to complain about staff using her trash can. She threw trash in the floor and hid her trash cans. Staff processed with [client #1] and tried to redirect her. She had already had a PRN (as needed) that morning. Staff followed [client #1] behavior plan and suggested her to stay in her room and listen to music. Staff also suggested other outings that can be done at a later date if she stays on task. [Client #1] wasn't hearing it. She begin to wish death on staff family member, calling staff the N word, making threats to get staff fired. Staff ignores [client #1] and she begin to get louder and more vocal with her insults. [Client #1] then begin to make threats to lock herself in the bathroom and hurt herself. Staff suggested that she come in the front room to be monitored. [Client #1] attempted to shut the door to her bathroom, staff went inside, stood behind [client #1] and walked her to front room, prompt her to have a seat. [Client #1] begin to make threats to get staff fired. Staff continued to cook supper. [Client #1] stated several times that she will not eat staff food. [Client #1] went back to her room to lay down, but was asked to leave door open to be monitored. Dinner was served, [client #1] was called but still refused. Once staff begin to clean kitchen, she ask to eat and her plate was made. After she ate, [client #1] went to her room and talked to herself out loud so staff can hear. She continued to make racial slurs. At that time it was shift change." Interviews on 9/12/24 with the House Manager revealed: -Staff #1 informed her on 9/7/24, at approximately	V 512		

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V 512	Continued From page 8 6:30 pm and on 9/9/24 that client #1 had "acted out" and "struck her nerve." -Staff #1 stated that she was "fine until she (client #1) kept calling her n****r and she lost it." -Staff #1 said that she put her hand over client #1's mouth when she kept calling her a n****r. -Staff #1 stated that she went into client #1's room and "pulled her into the living room." -Staff #2 informed her, on 9/7/24, that she witnessed staff #1 "pull her by her collar and grab her by the back of her head and told client #1 to say it again." -Staff #2 reported that she witnessed the incident during shift change. -Client #1 informed her of the incident on 9/11/24. -She was responsible for reporting incidents to the Administrator/Qualified Professional (A/QP) -She informed the A/QP, "she believed," on 9/11/24 after client #1 told her about the incident. -She had not informed management initially because she "did not think too much about it." Interviews on 9/11/24 and 9/12/24 with the A/QP revealed: -He began an internal investigation on 9/9/24 after reading the incident report regarding an incident that occurred on 9/7/24 involving staff #1 and client #1. -Although the 9/7/24 incident report did not indicate abuse or neglect, he decided to conduct an internal investigation based on his "gut feeling." -He was made aware of additional details regarding the 9/7/24 incident involving staff #1 and client #1 on 9/12/24 during his internal investigation. -The House Manager was supposed to report the incident but had not until 9/12/24. -There were no reported incidents of abuse or neglect in the previous 9/7/24 incident report.	V 512		

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V 512	Continued From page 9 -Staff #1 was suspended and placed on administrative duty on 9/9/24 and had not worked in the facility since. Review on 9/17/24 of a Plan of Protection written by the A/QP dated 9/17/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 9/18/2024 Staff [staff #1] will be retrained in Client Rights. ADA (Adaptive De-Escalation Alternatives) de-escalation training by Client Services Director. Staff [staff #1] will also be placed on administrative duties and not return to any house (facility) until 10/1/2024. Staff [staff #1] will also be on 90 days probation during which time she will be evaluated by her immediate supervisor and QP. 9/26/2024 L&J Homes Will have an all-staff training on Client rights, Abuse and Neglect and Exploitation of Clients. All staff will be retrained on ADA De-Escalation by [Client Services Director]. 9/23/2024 [Client Services Director and Owner] will convene a Human Rights Committee Meeting to inform them of the incident and the conclusion of QP's investigation and the findings of State DHSR (Division of Health Service Regulation) survey." Describe your plans to make sure the above happens. "QP will review [staff #1] progress to see if she has not had any more incidents. QP will review all incidents to ensure no clients right have been violated. QP will implement new Crisis Response Training. L& J Homes will add 24 hours submission of all incidents in writing but also retrain staff of the importance of chain of command." Client #1's diagnoses included: Schizoaffective Disorder - Depressed Type; Intellectual Developmental Disability - Mild; Hypothyroidism; Borderline Diabetes; History of Arnold-Chiari	V 512		

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V 512	Continued From page 10 Malformation. There was an incident on 9/7/24 that involved client #1 and staff #1. Client #1 became angry because she was unable to attend an outing of her choice. Client #1 made racial slurs and inappropriate comments about staff #1's family. It then escalated and staff #1 placed her hand over client #1's mouth, physically pulled client #1 out of her bedroom by the straps of her bra and dress, and proceeded to pull client #1's hair. A second staff had to physically intervene to remove staff #1 from client #1. The incident was reported to the House Manager on 9/7/24. The House Manager reported the incident to the A/QP on 9/12/24. Staff #1 was placed on administrative duty and did not return to work in the facility. This deficiency constitutes a Type A1 rule violation for serious abuse and failure to protect. This must be corrected within 23 days.	V 512		