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
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 109	Continued From page 1 NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview 2 of 2 Qualified Professionals (QP) (Residential Team Leader/QP and Residential Director #1/QP) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Cross-Reference: 10A NCAC 27G .5602 Staff (V290) Based on record review and interview, the facility failed to ensure the staff-client ratios enabled staff to respond to individualized client needs. Cross-Reference: 10A NCAC 27G .5603 Operations (V291) Based on record review and interview, the facility failed to ensure service coordination was maintained with other professionals responsible for treatment affecting 4 of 6 clients (#1, #2, #3, #4).	V 109	Ratios: Since July, 2024 this home has remained in compliance with staffing ratios. Leadership team for this site was removed and a new leadership structure has been put in place. Monarch identified the need for a manager for this single site and this position is being recruited. Until hired and trained, staffing will be managed by the newly appointed Director of Operation. Leadership team set up a daily meeting to review staffing issues, assess needs, and to develop action plans to meet any identified needs. This continues as of this date (October 2, 2024). Monarch will assess the needed continuance of these daily meetings after December 1st.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 109	Continued From page 2 Review on 8/15/24 of the Residential Team Leader/QP's personnel record revealed: -Hire date of 5/6/24. -Job title of Residential Team Leader/QP. Review on 9/3/24 of the Residential Director #1/QP's personnel record revealed: -Hire date of 8/1/22. -Job title of Residential Director. Interview on 8/14/24 and 8/23/24 with the Residential Team Leader/QP revealed: -Was responsible for the staff schedule and ensuring 2 staff were on duty, coordinating medical appointments, ensuring clients attended appointments, medical information was documented, and recommendations were followed and linking clients to day programing. Interview on 8/22/24 with the Residential Director #1/QP revealed: -Was responsible for the supervision of the Residential Team Leader/QP. -Assisted with the staff schedule. -Was responsible for ensuring that 2 staff were on duty at all times. Interview on 8/26/24 with the Vice President (VP) of Operations #1 revealed: -The Residential Team Leader/QP was primarily responsible for scheduling and the Residential Director #1/QP provided support when needed. -The Residential Team Leader/QP was responsible for coordinating medical appointments, ensuring clients attended appointments, medical information was documented, and recommendations were followed. Review on 9/4/24 of the Plan of Protection dated	V 109	Schedules will be reviewed by the Director weekly. Once a Team Leader is hired (currently recruiting) and trained they will assume this schedule review. Appointments: The newly assigned Director has identified medical needs and is scheduling all required appointments. In follow-up it was determined that some appointments had been completed but documentation was not obtained. Director will obtain all information and complete any follow-up needed, based on results. After a manager is hired and trained, this person will assume responsibility for managing medical status for each individual. TL will review the status of medical appointments quarterly and the Director will review/monitor via reporting monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 109	Continued From page 3 9/4/24 and written by the VP of Operations #2 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -Staff ratios will be followed as required by the needs of the 6 individuals served by 9-4-2024. -Management will ensure all appointments are scheduled as required by 9-13-2024. -Management will ensure a team meeting occurs with the new admission to identify available resources for a meaningful day by 9-13-2024. -Describe your plans to make sure the above happens. -In the absence of an assigned QP (Residential Team Leader), Monarch's (licensee) LTSS (Long Term Services and Supports) Director (Residential Director #2) will: -Staff were trained on staff ratios on 7-17-2024 and no additional incidents have occurred. -LTSS Directors [Residential Director #2] will be responsible for the Safety Plan implemented 7-5-24 and revised 7-9-24 by 9-4-2024. -LTSS Director, [Residential Director #2] will report scheduled and kept appointments to [Vice President (VP) of Operations #2], LTSS VP weekly to ensure recommendations are followed. Required appointments will be identified and scheduled by 9-13-2024. -LTSS Director, [Residential Director #2] will report to [VP of Operations #2], LTSS VP the outcome of the new admission's team meeting to discuss community resources for a meaningful day which could be provided by [Day Program Provider] by 9-13-2024. -The following has occurred prior to 9-3-2024. -Investigation for not having adequate staffing in the home with the outcome being substantiated and a safety plan implemented 7-5-2024 and amended 7-9-2024."	V 109	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 109	Continued From page 4 The facility served clients with diagnoses of Mild and Moderate Intellectual Developmental Disability, Down Syndrome, Unspecified Neurocognitive Disorder, Dementia, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Cerebral Palsy, Spastic Quadriplegia and legally blind resided in the facility. Three clients used wheelchairs. The Residential Team Leader/QP and the Residential Director #1/QP were responsible for ensuring the facility was staffed to meet the needs of the clients and had determined that based on the needs of the clients, 2 staff were required on each shift. On 6/28/24 1 staff worked alone from 10pm to 6am and was responsible for 5 clients. Then after a safety plan was put into place, on 7/6/24 the Residential Director #1/QP moved staff #4 from the facility to work in a sister facility leaving only one staff present with 5 clients from 10pm to 6am. Additionally, at least 7 medical appointments were missed since June 2024. Other appointments were not scheduled, and recommendations were not followed. Documentation of medical appointments was not maintained, and outcomes were not consistently communicated with the legal guardians. The Residential Team Leader/QP, who was responsible for coordinating appointments, had no system for tracking appointments and ensuring that the clients received the medical care they needed. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109	This page intentionally left blank.	
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 5 (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other	V 290	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 6 drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the staff-client ratios enabled staff to respond to individualized client needs. The findings are: Review on 8/12/24 and 8/23/24 of client #1's record revealed: -Admission date of 6/7/24. -Diagnoses of Mild Intellectual Developmental Disability (IDD), and Schizoaffective Disorder. Review on 8/12/24 of client #2's record revealed: -Admission date of 10/30/08. -Diagnoses of Profound IDD, Unspecified Neurocognitive Disorder, Down Syndrome, Hypothyroidism, Dementia with Agitation. -Required a wheelchair for mobility. -Nonverbal. -Physician's note from 4/9/24 recommended "1:1 sitter in the evening." Review on 8/28/24 of client #4's record revealed: -Admission date of 2/19/16. -Diagnoses of Cerebral Palsy, Bipolar Disorder. -Required a wheelchair for mobility. Review on 8/28/24 of client #5's record revealed: -Admission date of 10/29/24. -Diagnoses of Cerebral Palsy, Spastic Quadriplegia, Moderate IDD.	V 290	For individual #2: Physician to be contacted to clarify 1:1 "sitter" order. Physician's order will be updated with clarification. An OT assessment will be obtained for the individual. This will be scheduled by 10-31-24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 7 -Required a wheelchair for mobility. Review on 8/28/24 of client #6's record revealed: -Admission date of 11/27/24. -Diagnoses of Moderate IDD, Down Syndrome, Unspecified Neurocognitive Disorder. Review on 8/15/24 of staff #4's personnel record revealed: -Hire date of 10/29/23. -Title of Developmental Specialist Residential. Review on 8/9/24 of the North Carolina Incident Response Improvement System (IRIS) for the incident occurring on 6/28/24 for clients #1, #2, #4, #5, #6 revealed: -"It has been alleged that one staff was present for an overnight shift. Specific date given 6/28/24. Staff also alleged that this has happened before but did not have specific date. -This group home requires 2 awake staff on each shift due to the acuity of the home. -It has been alleged that there have been times in which the 2nd scheduled staff has been moved to another home while leaving this home out of ratio. -A safety plan has been developed to ensure there are 2 staff on each shift. If in a shortage, it is the expectation of the management team to find coverage or provide the coverage themselves. Any further incidents of failure to staff the home will be filed." Review on 8/9/24 of the North Carolina IRIS for the incident occurring on 7/6/24 for clients #1, #2, #4, #5, #6 revealed: -"Staffing pattern for this home is 2 awake staff when residents are all in the home. On 7/6 (2024) one of the staff assigned to [the facility] picked up a shift at another group home, leaving only 1 staff on duty from 10pm-6am.	V 290	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 8 -This is the 2nd allegation of neglect for this home within a short period of a time for failure to provide the appropriate level of support. This home had an implemented safety plan as follows: [The facility] requires 2 awake staff on each shift. Management will ensure all shifts are staffed with the required 2 staff members. If at anytime the requirement is not met, it is management's responsibility to ensure coverage. If coverage is unable to be identified, management is responsible to cover the shift. Failure to cover the shift will result in an allegation of neglect. The following is the chain of command: 1. [Residential Team Leader/Qualified Professional (QP)] or covering Residential Team Leader 2. Residential Director (#1/QP) 3. VP (Vice President) of Operations (#1). The safety plan was emailed to the staff (#4) that picked up another shift at a group home while scheduled for [the facility]. Staff (#4) has worked at this site for 9+ months under the [current licensee] licensure. Staff (#4) has been with [previous licensee] for 28+ years and should be aware of the staffing requirements." Interview on 8/16/24 with client #1 revealed: -Denied having times when only one staff was working. Attempted interview on 8/16/24 with client #2 was unsuccessful due to her being nonverbal. Interview on 8/16/24 with client #3 revealed: -There was only 1 staff present "when they can't get somebody to work." -Could not recall specific dates or times when only 1 staff was present. Interview on 8/16/24 with client #4 revealed: -Denied having times when only one staff was	V 290	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 9 working. Interview on 8/16/24 with client #5 revealed: -Did not "remember" if there were times with only 1 staff present. Interview on 8/16/24 with client #6 revealed: -Was unable to provide details due to answering yes to every question. Interview on 8/14/24 with staff #1 revealed: -Worked 2nd shift, 2pm to 10pm. -"It is supposed to be 2 (staff working per shift) but there have been times with only one." -"The month of May (2024) coming into June (2024) it was happening (only one staff on 2nd shift) ...every day or every other day because they (Residential Team Leader/QP and Residential Director #1/QP) couldn't find anybody to come in." -Staff #2 "was here (at the facility) by herself a few times." -Worked 2nd shift by herself in either June or July (2024). Couldn't recall the date. -Told the Residential Team Leader/QP and Residential Director #1/QP, "Y'all going to get someone here, it is too much (for 1 staff to work alone)." -Talked to the VP of Operations #1 "in June (2024) about it (1 staff on shift) being too much." Interview on 8/21/24 with staff #2 revealed: -Usually worked 2nd shift from 2pm to 10pm. -"I have worked with all 4 (clients) by myself." -"I worked 8 hours by myself twice." -Could not recall specific dates worked alone. -"It was hard giving showers, doing a 2 person job with 1 person." -It would be hard to evacuate in a fire "with 1 person (staff) with 2 (clients) in wheelchairs. I'd	V 290	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 10 do my best. Even if I had to go back in the line of danger." Interview on 8/16/24 with staff #3 revealed: -Usually worked 3rd shift, 10pm to 6am, but had filled in on all shifts. -Was supposed to have 2 staff on all shifts. -"Sometimes we got stuck (with one staff on shift)." -"We had to sign a paper that says there is always 2 people." -Had 3 clients in wheelchairs and one who was partially blind who needed assistance to evacuate in an emergency. -Worked alone from 10pm to 6am on 7/6/24 when her coworker, staff #4, was sent to the sister facility, by the Residential Director #1/QP to cover 3rd shift. -The Residential Team Leader/QP was aware she was working alone on 7/6/24. -The Residential Director #1/QP "said she didn't know I was there by myself." Interview on 8/21/24 with staff #4 revealed: -On 7/6/24, the Residential Director #1/QP "texted and asked me to work at [sister facility]. I said yes. I assumed that she knew I was on shift (scheduled to work 10pm to 6am at the facility)." -The Residential Director #1/QP was helping with the schedule due to a vacant Residential Manager position. -Thought the Residential Director #1/QP knew she was scheduled to work at the facility since she was responsible for developing the schedule. -Worked 3rd shift at the sister facility leaving only staff #3 present in the facility from 10pm to 6am on 7/6/24 with 5 clients. Interview on 8/22/24 with staff #5 revealed: -"There are 2 staff on shift now. At one point in	V 290	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 11 time, it wasn't. It changed with the investigations (related to staffing patterns)." -"I worked by myself a couple of times on 3rd shift and on 2nd (could not recall the dates)." -"People (staff) would call out at the last minute" leaving only 1 staff to work. -"Working on 2nd (shift) by myself was rough. You have to answer to all of them. Two in wheelchairs and one who was losing balance and had to use a wheelchair." -"My concern was if something was to happen I wouldn't have anyone to help me, like in a fire or break in or something." Interview on 8/14/24 and 8/23/24 with the Residential Team Leader/QP revealed: -With the exception of the month of July 2024, when the former Residential Manager was, working, the facility had been without a Residential Manager since he began working in May 2024. -In the absence of the Residential Manager he was responsible for the staff schedule, with the assistance of the Residential Director #1/QP. -The shifts were 6am to 2pm, 2pm to 10pm and 10pm to 6am. -Staffing ratio was 2 staff to 6 clients. -Clients #2 and #4 needed to assistance transfering in and out of their wheelchair. -Client #5 needed assistance from staff to use the Hoyer Lift to transfer in and out of her wheelchair. -"We are never fully staffed." -"We have been bringing in other staff (from sister facilities) to help out." -Staff #4 "left from this home (the facility) and went to another home (sister facility) and messed up the ratio (on 7/6/24)." -Staff #4 was asked by the Residential Director #1/QP to work at the sister facility. -On 8/23/24, sent 6 clients and 2 staff to a sister	V 290	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 12 facility with 4 clients and 1 staff because the second staff member at the sister facility called out of work. -"I don't have staff to come in until 4(pm) (at the sister facility). By the time they (staff and clients from the facility) get there it should be around 3 (pm). New staff is there (at the sister facility). It will be 3 staff to 10 clients, and they will be in ratio." -"It may push them back on dinner, but 9 times out of 10 they will just eat there. Everyone eats together. None of them like it." -"Sometimes we just don't have a choice. It happens maybe once a month." Interview on 8/22/24 with the Residential Director #1/QP revealed: -The Residential Manager is typically responsible for the staff schedule. -Since the Residential Manager position was vacant the responsibility fell on the Residential Team Leader/QP. -"While looking for staff (coverage), he (the Residential Team Leader/QP) can contact me and we can pull from other areas (sister facilities in nearby cities)." "We (the facility) found ourselves out of ratio and self-reported (6/28/24 incident of one staff working 10pm to 6am with 5 clients)." -"We did an in-service and made clear what the chain of command was." -Did not know the date of the in-service. -The chain of command was Residential Team Leader/QP, Residential Director #1/QP, VP of Operations #1. -"Shortly after (7/6/24) we had a scheduling error and staff (#4) accepted a bonus to work somewhere else (sister facility) leaving that house (the facility) out of ratio." -Did not know staff #4 was scheduled to work at	V 290	This page is intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 290	Continued From page 13 the facility when she asked her to work at the sister facility. "That should have been caught." -After making the error of sending staff #4 to the sister facility when she was already scheduled at the facility, "we put in place that schedules are up to date online in real time." -"The staffing pattern has always been 2 staff (per shift). I am not aware of it not being followed prior to these 2 incidents." Interview on 8/26/24 with the VP of Operations #1 revealed: -The facility required 2 staff per shift. -Was aware there had been problems with staffing ratios, but did not know details. -"I heard that something happened (on 7/6/24). It sounded like an error that staff said she would do this (work at the sister facility) and she didn't realize that she was on shift. That was my understanding." -"Typically the Residential Manager (is responsible for scheduling but since we didn't have one it would fall on [Residential Team Leader/QP]. -The Residential Director #1/QP provided scheduling assistance "when the Residential Team Leader/QP needed support. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 290	See tag 109 for corrective actions taken and to be taken.	
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 14 developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure service coordination was maintained with other professionals responsible for treatment affecting 4 of 6 clients (#1, #2, #3, #4). The findings are: Review on 8/12/24 and 8/23/24 of client #1's record revealed:	V 291	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 15 -Admission date of 6/7/24. -Diagnoses of Mild Intellectual Developmental Disability (IDD), and Schizoaffective Disorder. -After Visit Summary from the local hospital emergency department dated 6/18/24: "Reason for visit: Mental Health Problem. Schedule an appointment with [medical provider] as soon as possible for a visit." -No record of follow up appointment from the 6/18/24 emergency department visit. Interview on 8/16/24 with client #1 revealed: -Missed a couple of appointments because the van was not working. -Did not know the exact number of appointments, which doctor, or when they were. Interviews on 8/21/24 and 8/22/24 with client #1's guardian revealed: -"I have scheduled all of her (client #1) appointments." -On 6/5/24, in a meeting with the Residential Team Leader/QP, the Residential Director #1 and staff #6, requested that client #1 be linked with a local primary care physician and dietician. No provider had been identified and no appointment had been scheduled. -Client #1 missed appointments on 6/21/24 and 6/28/24 with the psychiatric provider to complete a Comprehensive Clinical Assessment (CCA). -Client #1 missed an appointment with the mental health therapist on 7/5/24. -Client #1 missed a gynecology appointment on 7/9/24 "due to staffing issues" according to the Residential Team Leader/QP. The appointment had not been rescheduled. -Client #1 missed an appointment with the dentist on 8/7/24. The appointment had not been rescheduled. -At client #1's admission requested a meeting	V 291	Client #1: All medical appointments have been scheduled and are being completed. Individual does not require a CCA due to diagnosis and services received. Current psychological to verify medical necessity is in place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 16 after 30 days to discuss client #1's progress and needs. -The facility did not schedule the 30 day meeting. -"On August 8th [Residential Director #1], [Residential Team Leader/QP] and I were supposed to have an in person meeting. [Residential Director #1] called and changed it (meeting) to a phone call because [Residential Team Leader/QP] couldn't be there. I called (at the agreed upon time) and I was not able to reach them (Residential Director #1 and Residential Team Leader/QP)." -The meeting had not been rescheduled. Review on 8/12/24 of client #2's record revealed: -Admission date of 10/30/08. -Diagnoses of Profound IDD, Unspecified Neurocognitive Disorder, Down Syndrome, Hypothyroidism, Dementia with Agitation. -Required a wheelchair for mobility. -Nonverbal. -5/13/24 Physician's order "Use wheelchair for transport to and from appointments." -Physician's note from 4/9/24 recommended "1:1 sitter in the evening." Attempted interview on 8/16/24 with client #2 was unsuccessful due to her being nonverbal. Interview on 8/23/24 with client #2's guardian revealed: -Client #2 missed an appointment on 7/9/24 with her primary care physician. -Client #2 missed an appointment on 8/5/24 with her psychiatrist. The appointment had not been rescheduled. -Client #2 needed to use a wheelchair at all times due to difficulty ambulating, however the current physician's order only indicated use to and from appointments. It needed to be updated.	V 291	30 day follow-up meeting was not held on schedule but was held by new leadership. Documentation of this meeting is in the record. Client #2: Physician's order to be clarified regarding 1:1 "sitter". Order will be updated to reflect a clarified status. An OT referral has been made.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 17 -Was not aware of the primary care doctor recommendation for a 1:1 sitter in the evening but felt it would be beneficial. Review on 8/12/24 of client #3's record revealed: -Admission date of 7/24/24. -Diagnoses of Mild IDD, Schizoaffective Disorder, legally blind in 1 eye and limited vision in the other. -No documentation of medical appointments since the admission date. Interview on 8/16/24 with client #3 revealed: -Had not had any appointments since her admission. -Wanted to go to the day program. Interview on 8/26/24 with client #3's guardian revealed: -On 8/7/24, asked the Residential Team Leader/QP to arrange appointments for primary care, dental, vision, and psychiatric care physicians located near the facility. -No appointments had been scheduled. -Requested client #3 be enrolled in a day program. -Was told by the Residential Team Leader/QP that he was "looking into" 2 programs in the area and "would get back with me." -Had not received follow up information regarding day programming. Review on 8/28/24 of client #4's record revealed: -Admission date of 2/19/16. -Diagnoses of Cerebral Palsy, Bipolar Disorder. --Required a wheelchair for mobility. Interview on 8/16/24 with client #4 revealed: -Did not "think" she had missed any appointments.	V 291	Client #3: Medical appointments have been scheduled Team meeting was held. Individual and guardian have toured the day facility of choice. Waiting on approval from the MCO for services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 18 Attempted interview on 8/26/24 with client #4's guardian was unsuccessful due to not receiving a return phone call as of the survey exit. Interview on 8/14/24 with staff #1 revealed: -The Residential Manager and Residential Team Leader/QP were responsible for appointments. -"Now we don't have a manager (Residential Manager) so it is the QP (Residential Team Leader/QP)." -Was typically not on first shift, 6am-3pm, when appointments were completed. -Was not aware of any missed appointments for clients. -Scheduled appointments were supposed to be written on the calendar. -Client #2 needed to use a wheelchair due to ambulation deficits. Interview on 8/21/24 with staff #4 revealed: -Usually worked third shift, 10pm-6am and did not typically participate in appointments. -Didn't have a Residential Manager (at the facility) and staff #6 who used to work first shift had been moved to a sister facility, leaving no staff available on first shift to take clients to appointments. -Had assisted by taking clients to appointments in the absence of available first shift staff. -Staff #6 took client #1 to an appointment "a while back" (couldn't remember the date) and was told upon arrival that she didn't have an appointment scheduled. -Scheduled appointments were supposed to be tracked on a calendar. Interview on 8/25/24 with staff #5 revealed: -Worked third shift,10pm-6am and had not taken clients to medical appointments.	V 291	Medical appointment tracking calendar is in place and available for all staff in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 19 -"They (staff) may have had to reschedule (clients medical appointments) but they got there." -Medical appointments were rescheduled "a couple of times because the van was messed up or in an emergency where they didn't have staff or somebody forgot to put it (the appointment) down (on the calendar)." -Learned about appointments by looking at the calendar or "word of mouth." Interview on 8/26/24 with staff #6 revealed: -Had worked first shift, 6am-2pm, at the facility until July (2024) when she was moved to the sister facility. -Had taken the clients to medical appointments prior to transferring to the sister facility and continued to help out (at the facility) when needed after the transfer. -"If an appointment was missed, I didn't have knowledge of it until the last minute. -Once took client #1 to a mental health therapy appointment and was told client #1 did not have an appointment when they arrived (couldn't remember the date). -Had no knowledge of client #1's missed appointments on 6/21/24, 6/28/24 and 7/9/24. -Took client #2 to the wrong doctor once (couldn't remember the date) because "I was thinking it was the one (doctor) in [nearby city]." -"I got the dates mixed up (for client #4's appointment) and it was rescheduled for the following Friday (did not remember date of appointment)." -Used to keep notes about client's medical appointments in a notebook but couldn't find the book. -The Residential Team Leader/QP learned of scheduled appointments from client #1's guardian via email. -The Residential Team Leader/QP would let us	V 291	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 20 know about appointments by text messages or phone calls. -"The ones (appointments) that were written on the calendar was not missed." -Took a "paper for the doctor to sign" to all appointments. -Form signed by the doctor was put into a folder. -"It was left up to [Residential Team Leader/QP] to come in and put it in the system (Electronic Health Record(EHR))." Interview on 8/14/24 and 8/24/24 with the Residential Team Leader/QP revealed: -Was responsible for "making sure (client's) appointments are completed and done by staff." -"We (facility) used to have a first shift (6am-2pm) staff but don't anymore." -Was trying to hire staff for first shift. -"It has been an issue getting appointments scheduled because we (facility) don't have staff." -"We (facility) need to revisit setting up therapy (mental health) appointments (for client #1)." -"I will be setting it (client #1's therapy (mental health) appointment) up." -Had trouble coordinating appointments because there was no first shift staff and no other staff available. -Was not comfortable taking female clients to medical appointments since he was a male. -Could utilize staff from other facilities to take clients to appointments but they are not familiar with the clients. -"We haven't established a dentist yet (for client #1)." -Could not find paper documentation of client #1's appointments with the exception of an Emergency Department visit on 6/18/24 and a mental health therapy appointment on 8/16/24. -"I don't have anything (medical information for client #1) in [EHR]."	V 291	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 21 -The Residential Director #1 was responsible for entering medical information in the EHR when he first started working. -It was his responsibility to enter medical information in the EHR once he was trained. -"Across the board everyone is not using the EHR. Medical information is still in binders (client records in the facility)." -Was not able to get client #1 scheduled with a primary care doctor since the nearby practice was not taking new patients. -"I'll try to call again, but if not, I can call the doctor where she was going and get her an appointment there." -Had not been able to locate a dentist that would take Medicaid for client #1. -Did not have knowledge of client #1's scheduled and missed appointment at the dentist. -Did not know if client #1's missed gynecology appointment on 7/9/24 had been rescheduled. -Client #3 "has not been to any appointment since her admission." -Client #3 had not been established with any local doctors. -"I am working on setting her (client #3) up for day program and other appointments." -Was unable to coordinate client needs "since it is just me and I am having to stop and do other things." -Client #2 needed to use her wheelchair at all times to prevent falls and needed assistance transfering. -Did not know if client #2 had an order to use the wheelchair all the time. -Client #2 did have 1:1 staffing in the evening because there were 2 staff present with 6 clients. -Client #2 needs 1:1 staffing because she needs staff to "feed her, bathe her, and clothe her." -The meeting that client #1's guardian had requested had been scheduled on 8/8/24. The	V 291	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 22 Residential Director "canceled it because I couldn't be there." It had not been rescheduled. Interview on 8/22/24 with the Residential Director #1 revealed: -Was aware of missed medical appointments for client #1 but was not aware of missed appointments for clients #2, #3, and #4. -Had a "supervisory discussion" with the Residential Team Leader/QP regarding organization and missed appointments, but could not recall the date and had no documentation. -Typically, the Residential Manager was responsible for appointments, but currently, in absence of a Residential Manager, "responsibility fell to [Residential Team Leader/QP]." Interview on 8/22/24 with the Vice President of Operations #1 revealed: -"Typically, the Residential Manager" was responsible for scheduling and coordinating appointments, "but in absence of one (Residential Manager) it would be [Residential Team Leader/QP]." -Was aware that client #1 had missed an appointment and that appointments had not been scheduled. -"I asked Residential [Team Leader/QP] to make sure they (medical appointment) are scheduled. I will have to check to make sure it has occurred." -"We do have an electronic health record where we track appointments." -The EHR had been in place since March 2024. -"Appointments should be placed in [EHR]." -The facility is still using notebooks. -"The Residential Manager is responsible (for putting information into the EHR), in this case (no Residential Manager) it would be [Residential Team Leader/QP]." -Could not locate information related to client #1's	V 291	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 291	Continued From page 23 medical appointments in the EHR or notebooks. -"I did not know so many appointments had been missed." -Was not aware of the doctor recommendation for 1:1 staffing for client #2 in the evenings. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 291	Previous leadership has been removed and new leadership installed. Appointments are being scheduled and completed. Staff ratios are being maintained to date.	
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; (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.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 24 (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; (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,	V 366	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 25 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to level III incidents. The findings	V 366	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 26 are: Review on 8/9/24 of the North Carolina Incident Response Improvement System (IRIS) for the incident occurring on 6/28/24 for clients #1, #2, #4, #5, #6 revealed: -"It has been alleged that one staff was present for an overnight shift. Specific date given 6/28/24. Staff also alleged that this has happened before but did not have specific date. -This group home requires 2 awake staff on each shift due to the acuity of the home. -It has been alleged that there have been times in which the 2nd scheduled staff has been moved to another home while leaving this home out of ratio. -A safety plan has been developed to ensure there are 2 staff on each shift. If in a shortage, it is the expectation of the management team to find coverage or provide the coverage themselves. Any further incidents of failure to staff the home will be filed." Review on 8/9/24 of the North Carolina IRIS for the incident occurring on 7/6/24 for clients #1, #2, #4, #5, #6 revealed: -"Staffing pattern for this home is 2 awake staff when residents are all in the home. On 7/6 (2024) one of the staff assigned to [the facility] picked up a shift at another group home, leaving only 1 staff on duty from 10pm-6am. -This is the 2nd allegation of neglect for this home within a short period of a time for failure to provide the appropriate level of support. This home had an implemented safety plan as follows: [The facility] requires 2 awake staff on each shift. Management will ensure all shifts are staffed with the required 2 staff members. If at anytime the requirement is not met, it is management's responsibility to ensure coverage. If coverage is unable to be identified, management is	V 366	Monarch has modified their process for investigations to ensure incidents receive immediate response. QM will contact Support Coordinators (Monarch investigative team) of reported level 2 or 3 incidents requiring review. The Support Coordinator will complete investigations. If unavailable, the investigation will be assigned to the Director of Operations. Weekly incident review team was established between QM and investigators to monitor status of investigations, report barriers and status of investigations and to make follow-up decisions. Weekly supervision is provided to Support Coordinators by Senior VP of LTSS to review all incidents and status of investigations. In this situation the incident was assigned out to previous leadership staff at its start. Needed follow-up was not completed and delayed the invesitgation and reporting. The above actions are in place to increase oversight of assignments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 27 responsible to cover the shift. Failure to cover the shift will result in an allegation of neglect. The following is the chain of command: 1. [Residential Team Leader/Qualified Professional (QP)] or covering Residential Team Leader 2. Residential Director (#1/QP) 3. VP (Vice President) of Operations (#1). The safety plan was emailed to the staff (#4) that picked up another shift at a group home while scheduled for [the facility]. Staff (#4) has worked at this site for 9+ months under the [current licensee] licensure. Staff (#4) has been with [previous licensee] for 28+ years and should be aware of the staffing requirements." Review on 8/9/24 of the North Carolina IRIS for the incident occurring on 7/29/24 for clients #1, #4, #5, updated on 8/2/24 revealed: -"Staff (#2) cursed at residents (clients) and would not allow them to access the kitchen or the living room when she (client #1) would want to watch TV with her blanket. Staff used curse words towards the resident." -"Staff (#2) is currently suspended and an investigation will be conducted. DSS (County Department of Social Services on 7/30/24) notified. All staff are trained upon hire and on an annual basis on Abuse, Neglect, Exploitation and client rights." Review on 8/9/24 of the North Carolina IRIS revealed: -No incident reported for client #3 for the incident on 7/29/24 related to abuse. Review on 8/19/24 of the facility's incomplete Investigation Summary written by the Long Term Service and Supports (LTSS) System Coordinator #1 of the incident that occurred on 7/29/24 revealed:	V 366	Investigators, or designee, will submit to QM a completed investigation, or a request for additional investigative time 5 days after knowledge of the incident. Senior VP will provide training to System Coordinators (investigators) on reporting investigative status to QM 5 days into the investigation so resolution can be noted or additional time requested.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 28 -Did not determine the cause of the incident. -Did not include corrective measures with specific timeframes for completion. -Did not assign persons to be responsible for implementation of corrections and preventive measures. -Was not completed within 5 working days of the incident. Review on 8/27/24 of the facility's incomplete Investigation Summary written by the Long Term Service and Supports (LTSS) System Coordinator #2 of the incidents that occurred on 6/28/24 and 7/6/24 revealed: -Did not include "Internal Review Team Determination and Recommendation" or "Employee Relations Recommendations." -Was not signed. -Was not completed within 5 working days of the incident. Interview on 8/9/24 with the Residential Team Leader/Qualified Professional (QP) revealed: -Was not involved in investigating the two staffing incidents or the allegation of abuse by staff #2. Interview on 8/15/24 with the Long Term Service and Supports (LTSS) System Coordinator #1 revealed: -It was the responsibility of the LTSS System Coordinator to lead investigations. -Abuse investigation of staff #2 was started on 8/1/24 by the Former Residential Manager. -Was given the responsibility for the investigation on 8/7/24. -Was trying to locate initial statements that had been completed but had not received them from the Residential Team Leader/QP. -Had not interviewed the clients. -Had not interviewed staff #2.	V 366	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 29 -When all information was gathered, the written report would be sent to the Residential Director #1/QP and the VP of Operations #1 to review and make recommendations. At that point the report would be sent to the internal review team and then to Employee Relations for the final approval. -Tried to get investigations completed in five days, but "most of the time it takes longer." -Did not issue written preliminary findings of fact within five working days of the incident. Interview on 8/15/24 and 8/19/24 with the LTSS System Coordinator #2 revealed: -Was responsible for completing the investigation of the incident on 6/28/24 and 7/6/24. -Started investigating on 7/5/24. -Was investigating the 2 incidents together since they were both related to improper staffing ratios. -Usually the Residential Team Leader/QP was responsible for getting initial statements, but that didn't happen in this case. -"It has taken a while to get information because they are so short staffed over there (at the facility)." -Was finished gathering information and was working on writing the summary. -The investigation summary would go to the Vice President (VP) of Operations #1 and the Chief Operating Officer for review and they had the opportunity to add additional comments. "Then Employee Relations has the final say." -Did not issue written preliminary findings of fact within five working days of the incident. Interview on 8/26/24 with the VP of Operations #1 revealed: -The LTSS System Coordinator #1 was investigating the 7/29/24 allegation of abuse against staff #2. -The abuse investigation report had been	V 366	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 366	Continued From page 30 submitted to Quality Management and HR, but there had been no response yet. -It took longer than usual to complete the investigation due to "staffing issues" at the facility and the LTSS System Coordinator #1 was working on another investigation before this one. -The LTSS System Coordinator #2 was investigating the incidents on 6/28/24 and 7/6/24 of being out of staffing ratio. -Did not know the status of the investigation related to staffing ratio. -Since neither investigation had been finalized, documentation could not be provided regarding the cause of the incidents, corrective measures, measures to prevent similar incidents and the person responsible for implementation of the corrections and preventive measures.	V 366	This page intentionally left blank.	
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	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 31 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 review and interview, staff #2 abused 4 of 6 clients (#1, #3, #4, and #5) and staff #1 failed to protect 4 of 6 clients (#1, #3, #4, and #5). The findings are: Review on 8/12/24 and 8/23/24 of client #1's record revealed: -Admission date of 6/7/24. -Diagnoses of Mild Intellectual Developmental Disability (IDD), and Schizoaffective Disorder. Review on 8/12/24 of client #3's record revealed: -Admission date of 7/24/24. -Diagnoses of Mild IDD, Schizoaffective Disorder, Legally blind in 1 eye and limited vision in the other. Review on 8/28/24 of client #4's record revealed: -Admission date of 2/19/16. -Diagnoses of Cerebral Palsy, Bipolar Disorder. -Required a wheelchair for ambulation. Review on 8/28/24 of client #5's record revealed: -Admission date of 10/29/24. -Diagnoses of Cerebral Palsy, Spastic Quadriplegia, Moderate IDD. -Required a wheelchair for ambulation. Review on 8/15/24 of staff #1's personnel file revealed:	V 512	Accused employee was terminated 09/24/24. HCPR submissions completed. Employee who failed to report timely received disciplinary action on 09/11/24. Director will make random shift observations to monitor interactions between employees and individuals receiving support. Results of these observations will be documented. After Team Leader is in place (being recruited) they will assume random observations with reporting to the Director. All staff have been retrained on abuse, neglect, and exploitation as well as the reporting requirements based on state and Monarch standards. This training will be completed with each new employee upon their hire as part of their orientation process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 32 -Hire date of 4/20/24. -Job title of Developmental Specialist Residential. -5/3/24 received Clients Rights, Abuse, Neglect, Exploitation training. Review on 8/15/24 of staff #2's personnel file revealed: -Hire date of 3/25/24. -Job title of Developmental Specialist Residential. -4/2/24 received Clients Rights, Abuse, Neglect, Exploitation training. Review on 8/9/24 of the North Carolina Incident Response Improvement System (IRIS) for the incident occurring on 7/29/24 for clients #1, #4, #5, updated on 8/2/24 revealed: -"Staff (#2) cursed at residents (clients) and would not allow them to access the kitchen or the living room when she (client #1) would want to watch TV with her blanket. Staff used curse words towards the resident." -"Staff (#2) is currently suspended and an investigation will be conducted. DSS (County Department of Social Services on 7/30/24) notified. All staff are trained upon hire and on an annual basis on Abuse, Neglect, Exploitation and client rights." Review on 8/19/24 of the facility's incomplete Investigation Summary written by the Long Term Service and Supports (LTSS) System Coordinator #1 revealed: -Email from Former Residential Manager dated 7/29/24: "[Client #5] reported that she heard [staff #2] swear at [client #4], when asked if this occurred, [client #4] confirmed it was true. [Client #4] stated it happened more than a few times." -Client #4 reported that staff #2 "had been mean to her and swore at her while in the bathroom, said d**n and a few other bad words she did not	V 512	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 33 want to repeat because she is a Christian, cursed at her on more than one occasion, but she went into detail about the most recent one that she said happened 3 weeks ago. No date was provided." -Client #5 "communicated that [Staff #2] was mean to them (clients). She (client #5) was asked if she heard [staff #2] say anything to [client #4] she nodded yes and said that she had said a curse word to her (client #4)." -Client #3 said that staff #2 "talks aggressive to her and when she asks for something she is told no. She witnessed ...[Staff #2] yelling at them (clients) to do their chores." -Staff #1 said staff #2 "yells at the residents (clients) while on shift and tells them no when they ask for additional food or snacks. She (staff #1) also said that [staff #2] cursed at one of the residents saying she is lazy and can do better. [Staff #1] noted that [staff #2] reportedly told another resident (client #1) no to food one night and put the food in the sink and down the disposal sending the individual to bed hungry. She also reported that [staff #2] yelled at them (clients) saying they do more dumb stuff than right. [Staff #1] said that she witnessed [staff #2] yelling at them (clients) to do their chores She (staff #1) said that [staff #2] yells at them daily and tells them no to everything they ask for." Interview on 8/16/24 with client #1 revealed: -Staff #2 "was being smart with me in the car." -"She was yelling, saying mean things, hurtful things." -Was unable to give dates or times. Interview on 8/16/24 with client #3 revealed: -Staff #2 "wasn't nice." -"I got attitude (unpleasant) from [staff #2]." -"Staff (#2) is rude, not Christian like. Just rude	V 512	This page left intentionally blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 34 and disrespectful." Interview on 8/16/24 with client #4 revealed: -"I was in the restroom and trying to get on the toilet and she (staff #2) yelled and cussed at me." -"I didn't like the way it made me feel." -"I told the supervisor (former Residential Manager) and that staff (#2) got suspended." Interview on 8/16/24 with client #5 revealed: -Staff #2 "kind of yelled at me." -"I like all of the staff except her (staff #2)." Thought staff #2 was mean to client #4. Interview on 8/14/24 and 8/29/24 with staff #1 revealed: -Worked second shift (2pm-10pm) with staff #2. -Staff #2 talked to clients "too aggressive...bossy, mean." -Staff #2 "would not let them (clients) sit in the living room. They had to go in their room and watch TV." -Staff #2 talked aggressively to clients and would not let them sit in the living room "since I started working (4/20/24). It got worse when [client #1] moved in." -"She (staff #2) wouldn't let [client #4] call her mom, she would make her do other things first." -"They (clients) would ask for snacks and she (staff #2) would tell them no. -Staff #2 put client #1's food down the garbage disposal when she did not want to eat right away. -Client #1 said "it (facility) didn't feel like home anymore (when staff #2 was working)." -"I heard her say to [client #4], 'Open your D (d**n) legs.'" -The statement to client #4 was made approximately a week before she reported to the former Residential Manager. -Client #4 "said she wanted to call management."	V 512	This page left intentionally blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 35 -"Reported to the former Residential Manager August 1st (2024) because we didn't have a manager (Residential Manager) for a while ...might have been July 30th (2024)" -Did not report sooner because she didn't have the contact information for the former Residential Manager. -The former Residential Manager started work on 7/1/24. -"I met her (the former Residential Manager) on the 16th (7/16/24) and got her number." -Tried to report concerns to the Residential Team Leader/Qualified Professional (QP), but he never returned the phone call (did not know the date). -Did not report to the Residential Director #1/QP because "she don't ever answer the phone." Interview on 8/21/24 with staff #2 revealed: -Was suspended for verbal abuse allegations. -Denied cursing or yelling at the clients. -Denied withholding food from client #1. -Had been trained in abuse prevention. -"Abuse is denying them (clients) food, their rights, their phone calls. Being treated like a human being. Hitting ...Cursing." -Denied verbally abusing any of the clients. Interview on 8/16/24 with staff #3 revealed: -After the investigation against staff #2 began, "[Client #4] said [staff #2] cursed her." -"I think she (client #4) told the manager (former Residential Manager)." -Client #4 was "nervous all day" when staff #2 was working but was better once she was suspended. Interview on 8/9/24 with the Residential Team Leader/QP revealed: -Client #3 made the initial abuse allegation against staff #2 (7/29/24) and reported it to the	V 512	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 36 former Residential Manager. -Staff #2 was suspended on 8/1/24. -"I was not here and I am not investigating." -"The Vice President of Operations #1 is investigating," Interview with the Residential Director #1/QP revealed: -The abuse allegation involving staff #2 initially came from the clients talking to staff. Was not sure of the date. -"The previous manager (former Residential Manager) took the initial complaint." -"I have not been involved (in the investigation)." -The facility's incident department (Long Term Service and Supports System (LTSS) Coordinator #1) was completing the investigation. Interview on 8/15/24 with the LTSS Coordinator #1 revealed: -Abuse investigation of staff #2 was started on 8/1/24 by the former Residential Manager. -The Residential Director#1/QP "transferred it (the investigation) to me" after the former Residential Manager resigned. -Was given the responsibility for the investigation on 8/7/24. -Investigations were usually started by the Residential Manager who obtained statements and the Residential Team Leader/QP who entered the information into IRIS. Then the LTSS Coordinator took the lead in the investigation. -Conducted investigations by reviewing documentation and constructing a draft report. -When the report was completed he would send to the Residential Director#1/QP and VP of Operations #1 who would review, make recommendations and send the report to the Internal Review Team who would review and send to Human Relations who would review and	V 512	This page left intentionally blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 37 give the final approval. -Was trying to locate initial statements that had been completed but had not received them from the Residential Team Leader/QP. -Had not interviewed the clients. -Had not interviewed staff #2. -Had not completed the investigation report or submitted it for review. Interview on 8/26/24 with the VP of Operations #1 revealed: -The LTSS System Coordinator #1 was investigating the 7/29/24 allegation of abuse against staff #2. -The abuse investigation report had been submitted to the Internal Review Team and Human Relations, but there had been no response yet. Review on 9/4/24 of the Plan of Protection dated 9/4/24 and written by the VP of Operations #2 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -All staff will be retrained on [licensee] Abuse, Neglect and Exploitation Policy with the focus being on the need to report suspicion of abuse, neglect or exploitation immediately to management by 9-9-2024. Progressive discipline will be issued to the staff (#2) who failed to report an allegation timely by 9-5-2024. -Describe your plans to make sure the above happens. - LTSS Director (Residential Director #2) or designated staff will Retrain the staff on [licensee] Abuse, Neglect and Exploitation policy by 9-9-2024. -The following has occurred prior to 9-3-2024: Investigation on allegation of abuse with the outcome being termination of employment for the	V 512	This page left intentionally blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 38 involved staff on 8-29-2024. The staff who failed to report an allegation timely will receive progressive discipline by 9-5-2024." Four clients with diagnoses of Mild and Moderate Intellectual Developmental Disability, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Cerebral Palsy, and Spastic Quadriplegia were abused by staff #2. The clients were yelled and cursed at on multiple occasions. Staff #1 was aware of the abuse occurring over a period of approximately 3 months and failed to protect the clients by reporting to a supervisor. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to	V 513	See V512	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 513	Continued From page 39 insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide services using the least restrictive and most appropriate method. The findings are: Review on 8/9/24 of the North Carolina Incident Response Improvement System (IRIS) for the incident occurring on 7/29/24 for clients #1, #2, #4, #5, #6 updated on 8/2/24 revealed: -"Staff (#2) cursed at residents and would not allow them to access the kitchen or the living room when she would want to watch TV with her blanket. Staff used curse words towards the resident." Review on 8/19/24 of the facility's incomplete Investigation Summary written by the Long Term Service and Supports (LTSS) System Coordinator #1 revealed: -The Former Residential Manager reported being told by staff #1 that "the PWS (people we support - clients) often goes in the kitchen and attempt to get food or snacks but they are put out of the kitchen by [staff #2]. Lots of times the PWS asks for snack after dinner and would be told no the kitchen is closed. This recently happened with the new resident [client #1] who asked for a snack last Thursday (7/25/24) night and was told No."	V 513	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 513	Continued From page 40 -The Former Residential Manager reported being told by staff #1 that "some of the ladies (clients) likes to bring a blanket into the living room to watch tv but are often yelled at by [staff #2] who redirects them to their bedroom to put the blankets up and watch tv in their individual bedrooms." -Client #4 stated "she usually calls her mom 2 times daily once she gets home and before bed. Now when she asks [staff #2] to use the phone she tells her, "No. not until you do what needs to be done. She says that she has only been allowed to call her mom once a day which makes her feel really bad." -Client #5 "said that [staff #2] tells them they can't have snacks all the time. -Client #1 stated "she asked [staff #2] for a snack and was told no." Interview on 8/16/24 with client #1 revealed: -Staff (#2) did not allow her to go into the kitchen or go into the refrigerator. -"When [staff #2] was there, she told us we had to eat what they (staff) were serving." -Staff #2 did not allow her to have a peanut butter and jelly sandwich when she didn't like what was being served. -"She (staff #2) told me I couldn't bring a blanket in the living room." Attempted interview on 8/16/24 with client #2 was unsuccessful due to her being nonverbal. Interview on 8/16/24 with client #3 revealed: -Staff #2 "would not let me get a drink out of the refrigerator." Interviews on 8/16/24 with clients #4 and #5 revealed: -Denied not being able to make phone calls,	V 513	This page left intentionally blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 513	Continued From page 41 watch television in the living room, take blankets in the living room, or have access to the food or drinks they wanted. Interview on 8/16/24 with client #6 revealed: -Was unable to provide details due to answering yes to every question. Interview on 8/14/24 with staff #1 revealed: -Staff #2 "would not let them (clients) sit in the living room." -"They had to go in their room and watch TV." -"She (staff #2) wouldn't let [client #4] call her mom, she would make her do other things first." -"They (clients) would ask for snacks and she (staff #2) would tell them 'no.'" Interview on 8/21/24 with staff #2 revealed: -Denied keeping clients from making phone calls, watching television in the living room, taking blankets in the living room, or allowing access to the food or drinks they wanted. Interview on 8/14/24 with the Residential Team Leader/QP revealed: -Clients are "free to use the phone any time they want to." -"[Staff #2] told them (clients) that they can't bring their blanket into the living room and can't access the kitchen." -"[Client #3] reported to one of the staff that [staff #2] wouldn't let her get a drink of water." -Clients should be allowed access to all areas of the facility.	V 513	This page left intentionally blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-400	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-HOFFMAN	1482 HOFFMAN ROAD GASTONIA, NC 28054

(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 An annual and complaint survey was completed on 9/4/24. Five complaints were substantiated (intake #NC00219180, NC#00220264, NC00220292, NC00220285, NC00221193) and one complaint was unsubstantiated (intake #NC00218671). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 6 current clients.	V 000	This page intentionally left blank.	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A	V 109		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Omar Polk BA, QP | TITLE: Residential Director | (X6) DATE: 10/04/2024