STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-117	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE AVENUE GROUP HOME	264 S BECKFORD DRIVE HENDERSON, NC 27536

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 9/25/24. The complaint was substantiated (intake #NC00220281). 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 5 and has a current census of 5. The survey sample consisted of audits of 2 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108	See Attached RECEIVED OCT 22 2024 DHSR-MH Licensure Sect	

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V 108	Continued From page 1 equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 1 audited paraprofessional staff (#1) had the minimum employee trainings. The findings are: Review on 9/18/24 of staff #1's record revealed: - Hire date 8/12/24 - Job Title: Direct Support Professional - No documentation of the following: - General organizational orientation - Training on client rights and confidentiality - Training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan - Training in infectious diseases and bloodborne pathogens Review on 9/19/24 of internal investigation findings report dated 9/3/24-9/5/24 written by the Executive Director revealed: - "[Staff #1] has not completed her medication class, her agency orientation, or all training required at this time ..." Observation on 9/25/24 at 10:39am revealed: - A white board hanging in the Licensee	V 108		

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V 108	Continued From page 2 administrative office with the following handwritten information: - "Upcoming Training...10/4 @ 1pm...Orientation...[staff #1]..." Review on 9/24/24 of Licensee's policy titled "Employee Training for Personnel Providing Services to Mental Health and Substance Abuse Services revealed: - "Employee orientation and ongoing training updates includes at a minimum the following: - general organizational orientation conducted within the first 30 days of hire to include introducation to the Company and its policies and procedures..." Interviews on 9/17/24, 9/18/24 and 9/25/24 staff #1 revealed: - Hire date was 8/12/24 - Began "shadowing" other staff at the facility on 8/23/24 - Given no restrictions about working with clients during "shadowing" except she was not able to administer medication - Received no training prior to beginning shadowing at the facility - She was given paperwork on 8/29/24 and the Human Resources (HR) Specialist "scanned" through the policies and procedures and told her it was her document and she could read it on her own - Had not read the information that was given to her - Signed documents affirming she received policies and procedures, including client's rights and abuse/neglect reporting on 8/29/24 - Only remembered reviewing human resources information, "everything went so fast" - She "shadowed" with former staff #4 (FS #4) for 8 hours on 8/31/24 and 8 hours on 9/1/24	V 108		

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V 108	Continued From page 3 - On 8/31/24, she was left alone for approximately an hour with client #3 while FS #4 took the other clients on an outing away from the facility - On 9/1/24, she was left alone for approximately 15 minutes with clients #1, #2, #3 and #4 while FS #4 left the facility for an unknown reason - On 9/5/24, she was asked to "fill-in" and she worked alone with clients #2, #3, #4 and #5 - She could not recall who asked her to work on 9/5/24 but she thought it was staff #2 - She worked alone for "a few hours" on 9/5/24 - She worked alone at the facility from 7:00am on 9/21/24 until 11:00pm on 9/22/24 - No other staff came to the facility on 9/21/24 or 9/22/24 to check-in with her - As of 9/25/24, had still not received general organizational orientation with formal review of policies and procedures, client rights and confidentiality, client specific training or training in infectious diseases and bloodborne pathogens Interview on 9/18/24 staff #2 reported: - Had worked at the facility for over 3 years - "It is typical for staff to shadow before starting to work" alone at the facility - New staff "usually go through trainings before shadowing" - Staff #1 did not have trainings before she started shadowing due to "a miscommunication between [the Executive Director] and [the Residential Manager]" - The HR Specialist scheduled staff #1 to work - Shadowing staff did the same things at the facility with clients that other staff did, but did not administer medication - New staff "can't work alone while they're shadowing"	V 108		

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V 108	Continued From page 4 Interviews on 9/18/24 and 9/25/24 the Residential Manager reported: - Was responsible for making schedules for staff at the facility - Preferred new staff had all their trainings first prior to working at the facility - With staff #1, she "was advised by HR (HR Speciailst) to go ahead and have her shadowing done before she did any training" - Was aware of staff #1 being left to work alone at the facility with clients on 8/31/24, 9/21/24 and 9/22/24 - She was not aware of staff #1 working alone with clients at the facility at any other time - There was "not a set time for new employees to get training" - Orientation was scheduled "maybe once every 3 months" and completed by the Executive Director - New staff "sometimes work here (the facility) 2 to 3 months without orientation" - New staff "could work alone without going through orientation" - Felt there was "a disconnect with new staff because they haven't been through orientation and don't know the policies and procedures" Interview on 9/25/24 the HR Specialist reported: - Had worked for the Licensee for 2 and a half years - Completed new hire packet with new employees prior to first day of employment - She provided them with the policies and procedures and had them sign to affirm they reviewed and understood including client's rights and abuse/neglect reporting - Any additional questions from new employees about policies and procedures would be directed to their Residential Manager - Formal new hire orientation was completed	V 108		

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V 108	Continued From page 5 by the Executive Director within 90 days of employment - No one would be scheduled to shadow before completing the new hire paperwork but they can work alone with clients at the facility without formal new hire orientation - Residential managers were responsible for making staff schedules and could decide when a new staff was able to work alone Interview on 9/20/24 the Qualified Professional (QP) reported: - Had worked part-time as the QP for the facility since 2014 - Did not know staff #1 began working without orientation - Believed the Executive Director completed orientation with new staff - Met with new staff to review client goals but "give them a couple months to get themselves familiar" with the clients and facility before he met with them - Had not completed any training with staff #1 - "She's only been there a month or so, so its coming up soon. Probably go the next weekend she will be working." Interview on 9/17/24 the Executive Director reported: - Staff #1 was new and still in training - New staff could start "shadowing" as soon as their employment offer letter was signed - Staff #1 "had not had all the training she needs yet," including orientation - Staff #1 would receive training on abuse and neglect reporting as a part of new hire orientation - Staff #1 started shadowing other staff at the facility, but she could not be alone with clients or administer medication - Staff #1's orientation would be completed	V 108		

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V 108	Continued From page 6 quickly to give her the training information needed	V 108		
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 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.	V 109		

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V 109	Continued From page 7	V 109		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 2 of 2 Qualified Professional staff (QP and Executive Director) demonstrated the knowledge, skills and abilities required by the population served. The findings are:

Review on 9/25/24 of the QP's personnel record revealed:
- Hire Date: 1/1/21
- Job Title: Qualified Professional, Part-Time
- Qualified Professional Part-Time Job Description that included the following:
  - "Provide clinical supervision (individual and group) to all direct care staff."
  - "Educate staff and enforce the individuals' right and services."
  - "Assess training needs; coordinate the orientation training and on-going and in-going service training for direct care staff."

Review on 9/25/24 of the Executive Director's personnel record revealed:
- Hire Date: 1/1/21
- Job Title: Executive Director
- Executive Director Job Description that included the following:
  - "Assure compliance with prompt reporting and procedures of defined incident reports"
  - "Assure that personnel are trained, informed of and comply with [the Licensee] policies and procedures"

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V 109	Continued From page 8 Review on 9/24/24 of Licensee's policy titled "Employee Training for Personnel Providing Services to Mental Health and Substance Abuse Services revealed: - "Employee orientation and ongoing training updates includes at a minimum the following: - general organizational orientation conducted within the first 30 days of hire to include introducation to the Company and its policies and procedures..." Attempted review on 9/25/24 of facility supervision records was unsuccessful as no reports were provided. Interviews on 9/17/24, 9/18/24 and 9/25/24 staff #1 revealed: - Hire date was 8/12/24 - Began "shadowing" other staff at the facility on 8/23/24 - Received no training prior to shadowing at the facility - Had not met with the QP for supervision or to complete any training - Shadowed with former staff #4 (FS #4) at the facility on 8/31/24 and 9/1/24 - Witnessed a level III incident with client #1 and FS $3 involving abuse and neglect on 9/1/24 and reported it to staff #2 on 9/2/24 - As of 9/25/24, had not received any additional training, including general organizational orientation, client rights and confidentiality, client specific training, training in infectious diseases and bloodborne pathogens, or any training related to abuse/neglect Interviews on 9/18/24 and 9/25/24 staff #2 reported: - Her direct supervisor is the Residential Manager	V 109		

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V 109	Continued From page 9 - Did not meet with the QP for clinical supervision - Was aware of the abuse and neglect by FS #4 on client #1 on 9/1/24 - No one had met with her to complete any additional trainings or supervision since the incident on 9/1/24 Interview on 9/20/24 FS #4 reported: - Had worked at the facility part-time for 7 years - Only worked on weekends - Met with the QP for specific issues, but never had regular meetings - Could only remember meeting with the QP twice to discuss issues related to client #3 and once for an issue related to client #1 - The QP only came to the facility when he was working if there was an admission scheduled for a new client - His direct supervisor was the Residential Manager Interviews on 9/18/24 and 9/25/24 the Residential Manager reported: - She was a paraprofessional - She was the direct supervisor for staff in the facility and met with them regularly - The QP did not meet with the direct care staff - Notified the QP and the Executive Director when there were incidents in the facility - Was notified of abuse and neglect by FS #4 on client #1 on 9/2/24 and notified the QP and Executive Director of the incident on 9/3/24 - Met with the Executive Director on 9/17/24 to discuss putting in-service trainings together for staff following the abuse and neglect on 9/1/24 but nothing was in place yet Interview on 9/20/24 the QP reported:	V 109		

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V 109	Continued From page 10 - Had worked part-time as the QP for the facility since 2014 - Provided supervision for the Residential Manager - Was responsible for conducting the annual refresher for clients rights training - Would meet with clients and direct care staff at the request of the Executive Director if there was an issue or complaint - Required to meet with part-time staff once a quarter - "Front office does abuse and neglect training as a part of orientation for new staff. I think [Executive Director] does it." - Met with new staff to review client goals but "give them a couple months to get themselves familiar" with the clients and facility before he met with them - Had not completed any training for client behaviors, client goals, or treatment plans with staff #1 - "She's only been there a month or so, so it's coming up soon. Probably go the next weekend she will be working." - He had been on vacation and was not involved in any steps taken related to the level III incident with client #1 and FS #4 Interview on 9/17/24 the Executive Director reported: - Staff #1 was new and still in training - New staff could start "shadowing" as soon as their employment offer letter was signed - Staff #1 "had not had all the training she needs yet," including orientation - Staff #1 would receive training on abuse and neglect reporting as a part of new hire orientation - Staff #1 started shadowing other staff at the facility, but "she could not be alone" with clients or administer medication	V 109		

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V 109	Continued From page 11 - Staff #1's orientation would be completed quickly to give her the training information needed - Was notified of 9/1/24 level III incident with client #1 and FS #4 on 9/3/24 - Completed thorough internal investigation of the "behavioral altercation that happened in the bathroom where [client #1] received an injury" but did not interview any clients, "I didn't see anything to be gained from speaking with them." - Had been on vacation the previous week so no additional measures or actions had been put in place - "I will be training or speaking with them (paraprofessional staff)."	V 109		
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 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	V 291		

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V 291	Continued From page 12 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 coordination of services for 1 of 2 audited clients (#1). The findings are: Review on 9/18/24 of client #1's record revealed: - Admitted: 10/1/21 - Diagnoses: Cerebral Palsy Unspecified, Generalized Idiopathic Epilepsy and Epileptic Syndromes not intractable without status Epilepticus, Anxiety Disorder Unspecified, Major Depressive Disorder recurrent in full remission, Mild Intellectual Disabilities, Unspecified Psychosis not due to substance or known physiological condition, Functional Urinary Incontinence, Essential (Primary) Hypertension, Generalized Edema, Vitamin B12 Deficiency, Anemia due to Intrinsic Factor Deficiency, Other Hyperlipidemia, Disorder of Bone Unspecified, Gastro-Esophageal Reflux Disorder with Esophagitis without bleed - Treatment Plan dated 4/1/24 revealed: "[Client #1] has a high threshold for pain and does not always identify when he is in minor pain." Review on 9/19/24 of client #1's September 2024 Medication Administration Record (MAR)	V 291		

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V 291	Continued From page 13 revealed: - Documentation of administration of Ibuprofen 600 mg (milligrams) (pain) on 9/2/24 at 8:00am - Notes on back of MAR "...Reason: leg ache; Result: he said his leg felt better; Hour: 9A; Initial: [staff #2]" - Documentation of administration of Tylenol 500 mg (pain) on 9/7/24 at 7:00pm - Notes on back of MAR "...Reason: hip pain; Result: still hurting; Hour: 10p; Initial: [staff #3]" - Documentation of administration of Tylenol 500 mg on 9/8/24 at 3:00am - Notes on back of MAR "...Reason: hip pain; Result: still hurting; Hour: 7a; Initial: [staff #3]" - Documentation of administration of Tylenol 500 mg on 9/8/24 at 7:00am - Notes on back of MAR "...Reason: hip pain; Result: still hurting; Hour: 9a; Initial: [staff #3]" Review on 9/24/24 of Facility Incident Report dated 9/2/24 revealed: - "Narrative Description of Incident: ...Did a body check on (client #1) at 8am on Monday Sept 2, 2024 with new staff (#1) present (shadowing)...Bruises were discovered on (client #1's) right chest area, right corner back area, right arm bruise, scratch on right back arm. Bruise on left leg by his knee, left inner thigh at the top..." - "Immediate Action Taken: Documentation of bruises and contacted supervisor." - "Person's Notified: - Residential Manager; Date/Time: 9/2/24 8:30A; Contacted By: [staff #2] - QP (Qualified Professional); Date/Time: 9/3/2024 3pm; Contacted By: [Executive Director] - Executive Director; Date/Time: 9/3/2024	V 291		

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	MHL091-117	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

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V 291	Continued From page 14 1:30p; Contacted By: [Residential Manager] - Parent/Guardian; Date/Time: 9/3/24 3:40p; Contacted By: [staff #2] - Case Management of MCO (Managed Care Organization); Date/Time: 9/3/2024 5pm; Contacted By: [Residential Manager] - Nurse; Date/Time: 9/3/24 2:48p; Contacted By: [staff #2] - Physician (blank)..." Review on 9/18/24 of internal investigation findings report dated 9/3/24-9/5/24 written by the Executive Director revealed: - "Findings: Pictures from 9/2 showed six fresh bruises and scratches on [client #1]. Another bruise was discovered on 9/4/2024 on his ankle. A review of body checks from 8/22/24 - 9/4/2024 showed no new marks on [client #1] from 8/22 - 9/1/2024. On 9/1 [Former Staff #4] (FS #4) noted a new mark on his left leg, and on 9/2/2024 [FS #4] noted a new mark on his upper thigh area near his groin. On 9/2/2024 [staff #3] noted a new mark on his arm and back. On 9/2/2024 [staff #2] noted a new mark on his left arm. Incident reports were completed on 9/2/2024. A fresh bruise was noted on his ankle on 9/4/2024. A review of behavior data, incident reports, and Communication Log shows no information on how the fresh bruises and scratches occurred. No supervisor was notified about the marks until 9/2/2024. The Executive Director was not made aware of the marks until 9/3/2024 at 1:30pm... - Conclusion:...The 6 bruises and marks were noticed on Monday, September 1, 2024, around 8am, and the Executive Director was not notified until 1:30pm on Tuesday, 9/2/2024. Staff who are shadowing in the home, as well as Lead Staff (staff #2) failed to notify the proper chain of command in a timely manner...Although the bruises and scratches appear superficial [the	V 291		

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V 291	Continued From page 15 Licensee] is going to have [client #1] evaluated by a physician..." Interview on 9/17/24 client #1 reported: - On 9/1/24, "I was going to the bathroom and he (FS #4) knocked me off the commode" - "I was in the floor. My hip hit the floor." - No one from the facility talked to him about being slung to the floor by FS #4 - Told staff #2 he was hurting after incident in bathroom - Staff #2 gave him Tylenol - "Kept telling them (staff) I was hurting. Told my mama, too. Interview on 9/17/24 client #1's guardian reported: - Was contacted on 9/3/24 and told that 6 new bruises were found on client #1 during a body check - "Nobody has told me anything" regarding the incident and the cause of the bruises - Asked that client #1 be taken to the hospital to be "checked out but they didn't want to do that" - "They said they thought the bruises were just superficial" - Spoke with the Executive Director on 9/4/24 and was told he was scheduled to see a doctor on 9/16/24 - Wanted him seen sooner and they took him to the local emergency room on 9/5/24 - "Think they said that he may have been complaining about his leg hurting" - Had x-rays at the emergency room but nothing was found to be broken - Stayed in town through the weekend and took client #1 out for breakfast on 9/8/24 - Noticed client #1 was "squirming" and when asked if he was hurting, he pointed to his left hip - Client #1 was back at the facility and his	V 291		

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V 291	Continued From page 16 breathing was heavy, he was pale, and he would not answer her or staff #3 - Staff #3 called and notified the Residential Manager of client #1's current condition and was told to call 911 - Ambulance took client #1 to a different local emergency room and he received more x-rays that revealed a hip fracture - Surgery to correct the fracture was discussed, but it was decided since client #1 is not ambulatory, he would receive physical therapy and his hip allowed to heal without surgery - Discharge plan from the hospital was not currently known Interviews on 9/17/24 and 9/18/24 staff #1 reported: - Witnessed FS #4 "sling" client #1 to the floor in the bathroom on 9/1/24 - Reported the witnessed abuse on client #1 by FS #4 to staff #2 on 9/2/24 around 8:00 am - Staff #2 completed body checks for client #1 and she noticed when staff #2 went to pick him up he groaned and he seemed like he was hurting - Bruises were noted at that time and staff #2 contacted the Residential Manager to inform her of the allegation - Client #1 did not report any pain for the remainder of the day on 9/2/24 or on 9/3/24 - Client #1 was taken to the Emergency Room on 9/5/24 Interviews on 9/18/24 and 9/24/24 staff #2 reported: - Staff #1 reported the abuse she witnessed on 9/1/24 between client #1 and FS #4 on 9/2/24 around 7:30am when she arrived for her shift - Body checks were completed each morning for client #1 upon waking him	V 291		

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V 291	Continued From page 17 - 9/2/24 body check revealed 5 new bruises on client #1 - After speaking with staff #1 and completing body check, she notified her supervisor, the Residential Manager - Client #1 was not reporting having any pain - "On Tuesday afternoon I notified the nurse and then [client #1's] mom" - "Told mom and the nurse that there were bruises and that [client #1] said he didn't know how the bruises got there" - "Usually if [client #1] has bruises, I call mom when it happens" - Didn't tell the facility's Registered Nurse (RN) that it was an allegation of abuse because she did not know what she could reveal - Client #1 did not express any pain throughout the week - Client #1's guardian requested he get some x-rays and he was taken to the emergency room on 9/5/24 - Hospital completed x-rays of left side and right arm but found nothing so he was discharged to the facility - On 9/8/24, his pain increased and guardian reported something was wrong with his hip and she wanted him examined - Client #1 went to a different emergency room via ambulance and another x-ray was taken that revealed a fracture in his hip Interview on 9/18/24 staff #3 reported: - Client #1 had scratches and bruises at the beginning of the week of 9/2/24 but he was told to just monitor him for signs of pain - Client #1 started complaining about his leg hurting and was up all night on 9/7/24 - On 9/8/24, he was in "really bad pain" - Called the Residential Manager and the Executive Director the morning of 9/8/24 and told	V 291		

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V 291	Continued From page 18 them he had been up all night in pain - Was told to continue to monitor his symptoms - Would ask client #1 how he was and he say he was "fine" - Client #1 went to breakfast with his guardian the morning of 9/8/24 - "Around 1:00pm, she (guardian) said he (client #1) was not acting right, he was not responding, so we called 911" - "Gave him Tylenol on Saturday (9/7/24) at 7:00PM and Sunday (9/8/24) at 3:00AM and 7:00AM" Interviews on 9/18/24 and 9/24/24 the Residential Manager reported: - Staff #2 notified her of 9/1/24 abuse by FS #4 on client #1 witnessed by staff #1 on 9/2/24 - Was on vacation and business was closed due to holiday - Staff #1 should have called her immediately when the abuse occurred - Asked staff #1 to write a statement of what she witnessed on 8/31/24 and 9/1/24 - Would typically notify the Executive Director right away, but it was a holiday and she wanted to have all the information from staff #1's statement before contacting the Executive Director - "I could have texted her (the Executive Director) to let her know something was going on." - Body checks were implemented for client #1 on 6/24/24 to occur 3 times daily - If bruises are noticed during body checks, staff would contact me, the RN and the guardian - Staff #2 talked to the RN and the guardian, but "thinks it was on Tuesday (9/3/24) when they did the incident report" - "There is no reason they didn't call on Monday. I was so in shock with the whole story that I didn't even tell her to call..."	V 291		

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V 291	Continued From page 19 - The RN "told us to just monitor the bruises when she was notified" because client #1 was not expressing any pain - Guardian requested client #1 go to the doctor on 9/3/24 but she was told that the RN advised to just monitor - An appointment was scheduled with his primary care physician but guardian called again on 9/5/24 and insisted he be taken to the emergency room immediately - "The only reason he (client #1) was taken to the ER when he was was because mom wanted him to be" - Requested x-rays of his left side and bloodwork at the emergency room - Nothing on x-rays from the emergency room and he returned to the facility on 9/6/24 - Staff #3 contacted the evening of 9/7/24 and reported that client #1 was in some pain and decided to give Tylenol 500mg - Staff #3 called back on 9/8/24 and stated client #1 was complaining of pain in thigh and was short of breath and not responding - Instructed staff #3 to contact 911 and he was immediately taken to a different local emergency room where they discovered a hip fracture Interview on 9/19/24 the facility's RN reported: - Was contacted on 9/3/24 by staff #2 about client #1 - Staff #2 reported client #1 had some "small bruises" but "there was no pain being reported" - Staff #2 described the bruises as "dime size on upper arm and another on the upper chest" - Typically notified of any concerns or medication issues - Staff #2 has been good about reporting concerns to her before the end of shift - Staff #2 stated on 9/3/24 that she could not confirm how client #1 received the new bruises	V 291		

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V 291	Continued From page 20 - Staff #2 did not send any pictures and described no swelling or complaints of pain - Staff #2 reported the bruises were only to the upper body - Advised that they continue to monitor for pain or swelling and contact her if there were any additional concerns - No contact about client #1 between 9/3/24 and 9/8/24 - Did not go on site to see client #1 based on staff #2's report - "Have gone on site to see him (client #1) most of the times there has been an incident but this time they (staff) did not tell me anything significant happened" - Staff #3 called her on 9/8/24 and notified her of the allegation of abuse - Staff #3 also reported that 911 was called earlier on 9/8/24 - "I reiterated to him that those calls should be coming to me right away." - "If they (staff) had told me about him (client #1) being thrown to the floor I would have told them to have him evaluated immediately. I would have had them call 911. For abuse, I would have advised them to check him out immediately." - Staff #2 "didn't describe any reports of abuse or a fall. That would have changed things." - Staff #3 stated "he didn't know if he could tell me" and stated "he had to get permission from his manager before he could tell me what happened" Interviews on 9/17/24 and 9/25/24 the Executive Director reported: - The Residential Manager made her aware on 9/3/24 of "a behavioral altercation that happened in the bathroom where [client #1] received an injury" from FS #4 - Staff #1 was shadowing FS #4 on 9/1/24 and	V 291		

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V 291	Continued From page 21 witnessed "altercation between [client #1] and [FS #4] - Staff #1 reported the "altercation" to staff #2 on 9/2/24 and they reported to the Residential Manager - Was notified of the allegation on 9/3/24 and immediately placed FS #4 on administrative leave pending investigation - Staff #1 submitted a written statement of what she alleged to have witnessed - Client #1 did have bruises and marks and staff #2 took pictures of the injuries - Client #1 was sent to a local emergency room on 9/5/24 - The report from the emergency room was that he had bruises and was dehydrated - By 9/8/24, client #1 was reporting pain in his leg so he was taken to a different local emergency room to be seen on 9/8/24 - The x-rays completed on 9/8/24 revealed a fractured hip - Should have been notified sooner about the allegations and client #1's injuries - "Had every intention of him (client #1) being checked out but he wasn't complaining and bruises appeared to be superficial. Internal policy says we have 5 days to complete internal investigation and part of our investigation was to have him checked by a physician" - Guardian was notified by staff #2 on 9/3/24 at 3:40 pm - The Residential Manager should have contacted her when she was notified on 9/2/24 - Staff #2 should have also notified her on 9/2/24 - The Residential Manager stated she did not contact her "because it was a holiday and she didn't want to bother me: - "I'm on call 24/7 so I'm always available" - Notifying the RN and guardian had always	V 291		

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V 291	Continued From page 22 been a part of incident reporting policy - Body checks started a couple months ago and contacting nurse and guardian "immediately or by end of shift" was a part of body checks - The Residential Manager was given a corrective action on 9/23/24 for not contacting her immediately Review on 9/25/24 of the Plan of Protection dated 9/25/24 signed by the Executive Director revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? - The Executive Director will schedule training for all staff regarding timely reporting, detailed reporting to all responsible clinical parties (QP/RN). Review of agency policy. No later than 10/4. - The Residential Manager has received corrective action on 9/23/24 for failure to timely notify. - The QP and Residential Manager will assure that any allegation of abuse/neglect is followed by hospital visit within 24 hours. - Describe your plans to make sure the above happens. - The QA/QI (Quality Assurance/Quality Improvement) will continue monthly to review all incident reports and ensure proper and adequate communication among all staff and teams. As well as following appropriate protocol." Client #1 had diagnoses of Cerebral Palsy Unspecified, Generalized Idiopathic Epilepsy and Epileptic Syndromes not intractable without status Epilepticus, Anxiety Disorder Unspecified, Major Depressive Disorder recurrent in full remission, Mild Intellectual Disabilities, Unspecified Psychosis not due to substance or known physiological condition, Functional Urinary	V 291		

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V 291	Continued From page 23 Incontinence, Essential (Primary) Hypertension, Generalized Edema, Vitamin B12 Deficiency, Anemia due to Intrinsic Factor Deficiency, Other Hyperlipidemia, Disorder of Bone Unspecified and Gastro-Esophageal Reflux Disorder with Esophagitis without bleed. The facility's failure to coordinate services for client #1 resulted in a delay of medical care. FS #4 abused client #1 on 9/1/24 resulting in client #1 sustaining injuries. Staff #1 witnessed the abuse and reported it to staff #2 the following morning. Staff #2 immediately completed a body check to determine extent of injury and administered one dose of Ibuprofen for leg ache. Staff #2 notified her supervisor, the Residential Manager, of the abuse. The RN and the guardian were not notified of the abuse until 2 days later. When staff #2 did notify the RN, she only reported client #1 having 2 dime size bruises around his chest area with causes unknown and experiencing no pain. Staff #2 did not provide information to the RN about the abuse on client #1, the extent of the bruising, or inform her of the dose of Ibuprofen administered. Based on information provided, the RN only recommended monitoring for any signs of pain. Staff #2 notified client #1's guardian of new bruising, cause unknown, after speaking with the RN. Client #1's guardian requested he be seen by a medical professional, but guardian was informed the RN only recommended that client #1 be monitored for pain. Following guardian's insistance, client #1 was taken to the emergency room for evaluation 4 days after the incident of abuse. The initial examination from the emergency room revealed no breaks or fractures and client #1 was discharged to the facility. Client #1 began reporting pain the day after returning from the emergency room and was administered 3 doses of Tylenol that night and the following morning for hip pain by staff #3. Staff #3 notified	V 291		

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V 291	Continued From page 24 the Residential Manager and the Executive Director of the increased pain and was told to continue to monitor. Two days after being discharged from the emergency room, client #1 was showing signs of distress, including breathing heavy, pale skin, and not responding to verbal questions. Staff #3 contacted the Residential Manager and was told to call 911. Client #1 was taken to another local emergency room and this time the examination revealed a fractured left hip. Client #1 was admitted to the hospital. The RN reported that she was not notified of client #1's increased pain until after client #1 had already been taken by ambulance. The RN was not notified of the abuse for 7 days and stated had she been given the details of client #1's injury initially, she would have recommended he receive immediate medical attention. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 291		
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	V 366		

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V 366	Continued From page 25 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. (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	V 366		

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V 366	Continued From page 26 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, 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	V 366		

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V 366	Continued From page 27 (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 policies governing their response level III incidents as required. The findings are: Review on 9/18/24 of client #1's record revealed: - Admitted: 10/1/21 - Diagnoses: Cerebral Palsy Unspecified, Generalized Idiopathic Epilepsy and Epileptic Syndromes not intractable without status Epilepticus, Anxiety Disorder Unspecified, Major Depressive Disorder recurrent in full remission, Mild Intellectual Disabilities, Unspecified Psychosis not due to substance or known physiological condition, Functional Urinary Incontinence, Essential (Primary) Hypertension, Generalized Edema, Vitamin B12 Deficiency, Anemia due to Intrinsic Factor Deficiency, Other Hyperlipidemia, Disorder of Bone Unspecified, Gastro-Esophageal Reflux Disorder with Esophagitis without bleed Review on 9/17/24 of Incident Response Improvement System (IRIS) revealed: - Level III incident submitted for client #1 on 9/4/24 - Cause of incident described as follows: "Staff (#1) alleged that another staff (former staff #4) pulled a client (#1) off the toilet and put him in the bathroom floor until he apologized for saying bad things to staff. The allegation is that the client	V 366		

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V 366	Continued From page 28 was on the floor for 10 minutes. The client does have bruises / marks. Investigation is under way." - Incident Prevention described as follows: "Follow proper protocol for transfers, behavioral outbursts and documentation." - Allegation Description: "It is alleged that staff member (former staff #4) slung a client (#1) from the toilet to the bathroom floor and made him stay there until her apologized for saying bad things about staff. Failure to use a gaitbelt and properly transfer total care client." - Physical Injury/Harm: "There are approximately 6 marks/bruises on the client." Attempted review on 9/25/24 of facility supervision records was unsuccessful as no reports were provided. There was no evidence of measures developed and implemented to prevent similar incidents from occuring and no assigned person to be responsible for implementation of preventive measures. Interviews on 9/18/24 and 9/25/24 the Residential Manager reported: - Was notified of level III incident involving client #1 and FS #4 on 9/2/24 - She notified the QP and the Executive Director of the incident on 9/3/24 - She notified the Local Management Entity (LME) Case Manager on 9/3/24 at 5:00pm - Met with the Executive Director on 9/17/24 to discuss putting in-service trainings together for staff following incident on 9/1/24 but nothing was in place yet Interview on 9/20/24 the QP reported: - Was aware of incident with client #1 and FS #4 on 9/1/24 - Had not met with any staff to do additional supervision or training to prevent similar incidents	V 366		

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V 366	Continued From page 29 from happening in the future, including trainings related to behavioral outbursts, safe transfers for non-ambulatory clients, documentation of behaviors, reporting abuse or neglect - He was on vacation and was not involved in any steps taken related to the level III incident with client #1 and FS #4 Interview on 9/17/24 the Executive Director reported: - Was notified of 9/1/24 level III incident with client #1 and FS #4 on 9/3/24 - Had not met with any staff to do additional supervision or training to prevent similar incidents from happening in the future, including trainings related to behavioral outbursts, safe transfers for non-ambulatory clients, documentation of behaviors, reporting abuse or neglect - Had been on vacation the previous week so no additional measures or actions had been put in place - "I will be training or speaking with them"	V 366		
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	V 512		

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V 512	Continued From page 30 governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 former staff (FS #4) abused and neglected 2 of 2 audited clients (#1 and #3) and 1 of 1 audited paraprofessional staff (#1) failed to protect 5 of 5 clients (#1, #2, #3, #4 and #5) from abuse and neglect. The findings are: Review on 9/18/24 of client #1's record revealed: - Admitted: 10/1/21 - Diagnoses: Cerebral Palsy Unspecified, Generalized Idiopathic Epilepsy and Epileptic Syndromes not intractable without status Epilepticus, Anxiety Disorder Unspecified, Major Depressive Disorder recurrent in full remission, Mild Intellectual Disabilities, Unspecified Psychosis not due to substance or known physiological condition, Functional Urinary Incontinence, Essential (Primary) Hypertension, Generalized Edema, Vitamin B12 Deficiency, Anemia due to Intrinsic Factor Deficiency, Other Hyperlipidemia, Disorder of Bone Unspecified, Gastro-Esophageal Reflux Disorder with Esophagitis without bleed - Treatment Plan dated 4/1/24 revealed: "[Client #1] uses a gait belt to transfer from his	V 512		

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V 512	Continued From page 31 wheelchair to the toilet. He requires physical assistance and close monitoring for all transfers... [Client #1] uses a shower chair, gait trainer, gait belt..." Review on 9/25/24 of client #2's record revealed: - Admitted: 9/23/21 - Diagnoses: Intermittent Explosive Disorder, Intellectual Disorder Review on 9/19/24 of client #3's record revealed: - Admitted: 11/22/21 - Diagnoses: Moderate Intellectual Disability, Cerebral Palsy, Intermittent Explosive Disorder Review on 9/25/24 of client #4's record revealed: - Admitted: 10/10/97 - Diagnoses: Bipolar Disorder, Moderate Mental Retardation Review on 9/25/24 of client #5's record revealed: - Admitted: 3/6/15 - Diagnoses: History of Alcohol Abuse/Dependence, Mild Intellectual Developmental Disability, Traumatic Brain Injury Review on 9/18/24 of staff #1's record revealed: - Hire Date 8/12/24 - Job Title: Direct Support Professional Review on 9/17/24 of FS #4's record revealed: - Hire Date: 3/12/19 - Job Title: Direct Support Professional - Suspension Letter dated 9/3/24 - Termination Letter dated 9/5/24 Review on 9/17/24 of Incident Response Improvement System (IRIS) revealed: - Level III incident submitted for client #1 on 9/4/24	V 512		

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V 512	Continued From page 32 - Cause of incident described as follows: "Staff (#1) alleged that another staff (FS #4) pulled a client (#1) off the toilet and put him in the bathroom floor until he apologized for saying bad things to staff. The allegation is that the client was on the floor for 10 minutes. The client does have bruises / marks. Investigation is under way." - Incident Prevention described as follows: "Follow proper protocol for transfers, behavioral outbursts and documentation." - Allegation Description: "It is alleged that staff member (FS #4) slung a client (#1) from the toilet to the bathroom floor and made him stay there until her apologized for saying bad things about staff. Failure to use a gaitbelt and properly transfer total care client." - Physical Injury/Harm: "There are approximately 6 marks/bruises on the client." A. The following are examples of how FS #4 abused and neglected clients #1 and #3: Review on 9/18/24 of internal investigation findings report dated 9/3/24-9/5/24 written by the Executive Director revealed: - "Conclusion:...The allegation involving the altercation in the bathroom on 9/1/2024 is Substantiated, based on direct witness account. [FS #4] admitted to placing [client #1] in the bathroom floor, which is not in his PCP (Person Centered Plan), or any behavioral guideline. He failed to document the event correctly in any form, despite knowledge of how to do so. It is believed that the bruises and marks came from this altercation...The allegation that [client #1] was not placed in his gait belt or toilet seatbelt on 8/31 and 9/1/2024 is Substantiated, based on direct witness account. Additionally, [client #1] would not have been able to fall off the toilet, and [FS #4] would not have been able to grab him and swivel	V 512		

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V 512	Continued From page 33 him to the floor if he was fastened in correctly. Failure to use his belts would be neglect of [client #1's] safety. The allegation of speaking harshly to clients is Substantiated based on direct witness account. It is believed food was offered, via cereal, no one without food availability. [Client #1] refused breakfast, but did eat fruit. The way in which [FS #4] spoke was harsh, intimidating and unacceptable...There was an inquiry into [FS #4] on 6/7/2024 in which there was no evidence to prove misconduct. Based on the findings of the investigation, [FS #4's] employment will be terminated with [the Licensee] effective immediately." Interview on 9/17/24 client #1 reported: - On 9/1/24, "[FS #4] beat me up" in "my bedroom and the bathroom." - "I was going to use the bathroom and he (FS #4) knocked me off the commode." - "I was in the floor. My hip hit the floor." - "Don't remember if he was yelling." - "I thought he was a nice guy." - "Sat there for a while." - "He helped me back up. Sat me in my wheelchair." - "Helped clean me up and get me dressed." - "After the bathroom" FS #4 yelled at him in his bedroom - FS #4 "picked me up from wheelchair and threw me on the bed." - "Felt pain when it happened." - "Didn't tell him. I was scared of him." - During a different incident, FS #4 "threw me into couch the day that I got a black eye" - "Didn't do that often. Don't know why he did it that day." - "I thought he was my friend." - "Woke up wet and he wouldn't change me." - "Sometimes I ate breakfast in wet clothes."	V 512		

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V 512	Continued From page 34 - "That upset me and I told him." Interview on 9/17/24 client #3 reported: - Lived at the facility for 3 years - FS #4 "used to put his hands on me." - On one occasion, FS #4 "punched me in the face when he got me out of bed. I was arguing with him." - "When I went to get something out of the fridge that same night, he did it again." - Not certain how long ago that happened, but it was not recent - "Told my mom it happened and I think my mom told someone." - "Told [Residential Manager] that one time he was cooking food I got an apple and he came out of the room and grabbed the apple out of my hand." - "Did not tell [Residential Manager] about him hitting me in the face." - "Would make me happy if he wasn't working there anymore." - FS #4 "was putting [client #1] on the couch and he threw him on the couch. That was a couple of weekends ago. That same weekend, [client #1] came out of chair and fell in the floor." - FS #4 would curse and threaten, "I'm going to beat you." - "I would stay in my room and sleep all day. I would hide from him." - "Told my mom I was afraid." - Was not aware of the situation with FS #4 and client #1 in the bathroom Interview on 9/17/24 client #1's guardian reported: - Had been uncomfortable with FS #4 since client #1 admitted to the facility - "Noticed when [FS #4] was working [client #1] wasn't wearing seatbelt for his wheelchair and	V 512		

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V 512	Continued From page 35 [client #1] would tell him he needed the seatbelt but [FS #4] would say he didn't need it around him and he wouldn't let him fall" - Client #1 called her every night and staff would dial for him - On weekends FS #4 worked, client #1 did not call - Client #1 would say "I don't like" FS #4 but he did not want to speak up because he did not want to get him in trouble - Facility started doing body checks because client #1 had so many bruises of unknown source - Staff from the facility called on 9/3/24 and said they had found 6 bruises on client #1 - Nobody had told her anything else - The police did contact her about FS #4 - Staff did confirm the bruises occurred after FS #4 had worked with client #1 - X-rays completed at emergency room on 9/5/24 revealed nothing broken but he still seemed to be in pain - On 9/8/24, taken to another emergency room via ambulance - In the ambulance, client #1 told the ambulance staff "[FS #4] did it" - The second set of x-rays revealed a hip fracture - Surgeon felt because client #1 is non-ambulatory, recovery would be easier if they allowed him to heal on his own for 6 weeks - Client #1 will not be returning to the facility, "never going back there" Interview on 9/17/24 client #3's guardian reported: - Client #3 had been living at the facility for 3 years - "His behavior was always different with one staff on shift, [FS #4]" - "He (client #3) was afraid of him (FS #4). He	V 512		

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V 512	Continued From page 36 wouldn't come out of his room." - "He never touched him that I know of but he talked to him, maybe threatened him." - FS #4 would never return calls when he was on shift - Client #3 was "afraid to ask [FS #4] for food." - "One day I asked [client #3] to put his phone in his pocket (while still connected and listening) and go ask [FS #4] for food. [FS #4] yelled at him but I couldn't make out what he said." - Informed the Residential Manager of concerns and she said she "would handle it" - "One time [client #3] said [FS #4] did something to him in his bed...maybe he picked him up and threw him on the bed. I definitely told [the Residential Manager] about that." - "I knew it was being handled." - Also spoke with the Executive Director about concerns - "I didn't realize exactly how fearful he was of him...used his words to scare him" - The Executive Director said she would meet with FS #4 - "I was a little frustrated because it was like she (the Executive Director) was downplaying it" - A meeting was set up with FS #4, the Qualified Professional (QP) and client #3 at a local coffee shop - The Executive Director reported the meeting "went well and she was positive about it but nothing really changed" - Was taking client #3 home on weekends that FS #4 was working because client #3 was scared - Noticed on weekends FS #4 worked, the house would be dark with no lights on and all clients in their bedrooms during the day time hours - When other staff were working, the house was "lively and everyone was out" - Client #3 stated "I can finally come out of my	V 512		

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V 512	Continued From page 37 room" Interviews on 9/17/24 and 9/18/24 staff #1 reported: - Began shadowing staff in the facility on 8/23/24 - Was shadowing with FS #4 for 8 hours on 8/31/24 and 8 hours on 9/1/24 - Observed concerning things with FS #4 throughout the weekend - Had concerns with FS #4's tone and demeanor with clients - Clients "seemed scared and fearful" of FS #4 and FS #4 would say things like "this is the way I run this house" - Client #3 woke up late and when he requested breakfast, FS #4 responded "you know the process, you know to get up and out of bed to eat....I run this house. I dare them to go to the pantry and try to get food" - FS #4 was not using client #1's gait belt for transfers throughout the weekend and stated "that takes too much time" - On 9/1/24, client #1 was still in bed and had soiled himself - Client #1 wanted to get out of bed and changed from his soiled clothing and FS #4 stated he would get him up - FS #4 got client #1 out of bed and brought him to the table for breakfast - Client #1 was refusing to eat and told her that he was still in clothing soiled with urine - FS #4 stated to client #1 "you're gonna stay like that cause I need to make myself breakfast. You just won't eat then" - FS #4 stated to her "this is what they do. I'm not gonna stop doing what I do for them." - Client #1 was offered and ate fruit in lieu of his breakfast due to being upset about being soiled at the table	V 512		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 38 - FS #4 told her not to change him and that he would do it - FS #4 finished eating and then took client #1 to get cleaned up and put on dry clothes - On 9/1/24 around noon, she heard client #1 call her name from the bathroom - When she entered the bathroom, client #1 was alone in the bathroom and sitting on the toilet without his adaptive chair or belt and his pants and pull ups around his ankles - Client #1 was leaning forward and she placed her hand on him to hold him up - Client #1 had urinated on the floor and was saying "he (FS #4) don't care about me" - FS #4 entered the bathroom and stated "you're gonna say I don't care about you and I just cleaned up all this s**t" - FS #4 moved her to the side and client #1 began to punch at him, but was not able to make contact - FS #4 "then took him (client #1) and slung him down to the floor on to his left side and he was propping his head up with his arms, his pants and pull up was still down around his ankles" - "It happened so fast, I don't remember if [client #1] made any noise" - Client #1 "didn't cry, he just looked like he was in shock" - FS #4 said "You're gonna lay there until you apologize" - Client #1 laid on the floor between 7 to 10 minutes with his pants and pull up down at his ankles - FS #4 was "really angry" - Wanted to help client #1 and clean him up but FS #4 kept telling her no - Client #4 came into the bathroom and she took him back into his room and stayed with him to keep him distracted - Heard client #1 say "I'm sorry," FS #4	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-117	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

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V 512	Continued From page 39 responded "what are you sorry for," client #1 responded "I don't know" and FS #4 responded "well you're going to lay there until you understand what you did" - By the time she returned to the bathroom, FS #4 was cleaning him up and getting him off the floor - Client #1 was quiet the remainder of her time at the facility on 9/1/24 - Left the facility at 4:00 pm on 9/1/24 leaving FS #4 alone with all 5 clients from 4:00pm until 11:00pm when staff #3 was scheduled to arrive - Other staff acknowledged that FS #4 interacted with the clients differently and felt the clients' demeanors were different after weekends that FS #4 had been working - Noticed that the facility and the clients were quiet during the weekend with FS #4 - FS #4 stated "I work 2 other jobs...this is my chill weekend to relax and I have them trained. You see all them stuck in their rooms all day and its peaceful and quiet. That's how I got them trained." Interview on 9/18/24 staff #2 reported: - Had worked at the facility for 3 years and 5 months - Was made aware on 9/2/24 around 7:30am of abuse and neglect by FS #4 on client #1 that occured on 9/1/24 - Staff #1 reported FS #4 "took both hands and grabbed [client #1] and slammed him down on floor." - Body checks were completed each morning for client #1 upon waking him - 9/2/24 body check revealed 5 new bruises on client #1 - Had never worked with FS #4 on shift - Client #3 had mentioned FS #4 speaking harshly and client #3 did have some ongoing fear	V 512		

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V 512	Continued From page 40 of FS #4 - Client #3 would stay secluded in his room when FS #4 worked - Client #3 was never in his room when she worked - Had mentioned that to the Residential Manager in the past and she did speak with FS #4 - Client #3 did not say anything else after that - Was not aware of any additional issues with FS #4 Interview on 9/20/24 FS #4 reported: - Had worked at facility for 7 years and worked every other weekend - Always worked alone - Staff #1 was shadowing on 8/31/24 and 9/1/24 - Took client #1 to the bathroom and sat him up on the toilet - Staff #1 stepped in to see what was going on and he stepped out to remove soiled clothes and linens - When he returned, client #1 began lashing out, aggressively swinging but was not hitting anyone - Staff #1 walked away to assist another client - Client #1 was about to fall from the toilet and he "intercepted and swiveled and put him in the floor, then I picked him right up and put him back on the toilet" - Staff #1 returned to the bathroom and asked if something was wrong - "I said nothing is wrong and then i just kept going with my day, cleaning and getting him dressed" - Client #1 was wearing his safety belt but was still falling - "Don't know how he fell, He has unlatched his belt in the past but don't know how he did or	V 512		

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V 512	Continued From page 41 when. Belt had to be completely undone in order for him to fall in the floor like that." - No behaviors or issues for the remainder of the day - Documented that client #1 had a mark on the side of his leg on his knee area but there were no complaints of pain - Client #1 did not wake up soiled on 9/1/24 and he was never taken to the table wet for a meal - Clients typically ate meals together but that weekend, most didn't want the breakfast he had made - No one was denied breakfast or food for not coming to a meal on time - The Executive Director contacted him Tuesday or Wednesday stating there were allegations against him - A written statement was provided and he was shown pictures of bruises that were taken on 9/2/24 - "One bruise was the one that I put on the body check but the other ones I didn't know anything about" - Client #1 "bruised really easily moving around in bed, adjusting himself at night" - The Executive Director told him that she was "being pressured and would have to do something this time" - Police came to his home and job to speak with him and he notified the Executive Director that day that he was resigning - His direct supervisor was the Residential Manager - The Residential Manager told him that she got reports about him all the time but there was nothing she could do and told him "not to worry about it and keep doing what I do" - No incidents with any other clients in the home	V 512		

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V 512	Continued From page 42 - Met with the QP about one issue of reports that he was rough when putting client #1 in bed and another about ensuring food is left out for clients - The food issue was related to client #3 because he would sleep all day long - That was about 6 months ago - No one had ever stated clients were fearful of him or that he spoke harshly to clients - Never had been physically aggressive with any of the clients or withheld food as punishment Interview on 9/18/24 the Residential Manager reported: - Was made aware on 9/2/24 by staff #2 of 9/1/24 abuse and neglect by FS #4 on client #1 and witnessed by staff #1 - Requested a written statement from staff #1 and learned of additional concerns including client #1 being brought to breakfast in clothing soiled in urine by FS #4, FS #4 not using client #1's gait belt for the extent of the weekend, and speaking harshly to client #3 regarding breakfast on 8/31/24 - Body checks had been implemented three times a day for client #1 due to frequency of bruising - There had been allegations about 6 months ago regarding client #3 stating he was fearful of FS #4 - The Executive Director and the QP were notified and the QP spoke with client #3 and FS #4 about the issue - Only found that client #3 did not feel he could ask FS #4 for anything - No previous reports of physical aggression by FS #4 on clients - Client #3's guardian requested they look into why client #3 was fearful	V 512		

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V 512	Continued From page 43 Interview on 9/20/24 the QP reported: - Had been working at the facility part-time since 2014 - Was aware of the abuse and neglect allegations for FS #4 but he was not involved in the internal investigation - Just knew the "investigation was underway" - One issue in the past, about 5 to 6 months ago - Went to the facility and met with client #1 and FS #4 because client #1 reported FS #4 was handling him roughly during transfers - That was a complaint from client #1's guardian - Did not uncover anything during that investigation - Was aware of a previous issue that included "the way [FS #4] was speaking with [client #3] and his tone of voice..." - "[Client #3] was scare of him (FS #4)." - Brought FS #4 and client #3 together to discuss any issues - Did not speak to client #3 alone and did not see a reason to - "Everything came out wonderfully from that. Solved the problem right there." - FS #4 had a "military voice and his tone needed to be brought down" - No concerns since that meeting Interview on 9/17/24 the Executive Director reported: - Was aware of "a behavioral altercation that happened in the bathroom where [client #1] received an injury" from FS #4 on 9/1/24 - Was not notified of the incident until 9/3/24 - FS #4 was immediately placed on administrative leave upon her being notified - A thorough internal investigation was completed	V 512		

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V 512	Continued From page 44 - Received written statements from staff #1 and FS #4 and interviewed both of them - Reviewed documentation and body checks, and took pictures of new bruises beginning on 9/2/24 - "Substantiated" the allegation that client #1 was taken to the breakfast table wearing clothing soiled with urine - Substantiated the allegation that FS #4 was not using the gait belt and adaptive bathroom chair for client #1 throughout the weekend - "During allegation it was said that [FS #4] spoke rudely to [client #3]. That was substantiated." - "Allegation from altercation between [FS #4] and [client #1] was substantiated and injuries did come from that." - FS #4 was terminated on 9/5/24 - In June, client #1's guardian reported FS #4 was being rough with client #1 while in the shower - Client #1's guardian did not like FS #4 - Client #1's guardian had "baited" client #1 into saying things in the past but there was not a substantiated claim until now - "There was a time in July that [client #1] undid his seatbelt and leaned forward and fell out of wheelchair and bruised his eye. It was [FS #4] working at that time, as well." - Other staff had witnessed client #1 undo his seatbelt - No other staff ever reported seeing or hearing anything concerning about FS #4 B. The following are examples of how staff #1 failed to protect clients #1, #2, #3, #4 and #5 from abuse and neglect: Review on 9/18/24 of internal investigation findings report dated 9/3/24-9/5/24 written by the	V 512		

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V 512	Continued From page 45 Executive Director revealed: - "[FS #4] was scheduled to work the entire weekend. [Staff #1] was scheduled to work 8 hours on Saturday (8/31/24) and 8 hours on Sunday (9/1/24), to 'shadow' [FS #4] as she is a new hire...[Staff #1] has not completed her medication class, her agency orientation, or all training required at this time. She reported the incident to [staff #2] on Monday 9/2/24, Labor Day. The incident should have been reported the day it occurred....[Staff #1] felt intimidated. She stated that she thinks they fear him and she herself didn't want to overstep him..." Interview on 9/17/24 client #1 reported: - "I was going to use the bathroom and he (FS #4) knocked me off the commode." - "I was in the floor. My hip hit the floor." - "Don't remember if he was yelling." - "Sat there for awhile." - "After the bathroom" FS #4 yelled at him in his bedroom - FS #4 "picked me up from wheelchair and threw me on the bed." - "Felt pain when it happened." - "Didn't tell him. I was scared of him." Interview on 9/17/24 staff #1 reported: - Began "shadowing" other staff at the facility on 8/23/24 - Previously worked in a nursing facility for 7 years - Given no restrictions about working with clients during "shadowing" except she was not able to administer medication - Received no training prior to beginning shadowing at the facility - She was given paperwork on 8/29/24 and the Human Resources (HR) Specialist "scanned" through the policies and procedures and told her	V 512		

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V 512	Continued From page 46 it was her document and she could read it on her own - Had not read the information that was given to her - Had no formal training on reporting abuse or neglect - Only remembered reviewing human resources information, "everything went so fast" - "Shadowed" with FS #4 for 8 hours on 8/31/24 and 8 hours on 9/1/24 - Concerned on 8/31/24 and 9/1/24 with FS #4's interactions and response to clients in the facility, "his tone, his demeanor" - Clients in the home "seemed scared and fearful" of FS #4 - FS #4 was not using gait belt for client #1 during transfers and not using adaptive chair when client #1 was toileting - FS #4 restricted food from clients that were late to meals - FS #4 left client #1 in soiled clothing for approximately an hour during breakfast on 9/1/24 - On 9/1/24 around noon, she witnessed FS #4 "sling" client #1 to the floor on to his left side and he was propping his head up with his arms, his pants and adult incontinence brief still down around his ankles - FS #4 stated to client #1 "You're gonna lay there until you apologize" and client #1 remained in the floor for 7 - 10 minutes - FS #4 was "really angry" - Wanted to help client #1 and clean him up but FS #4 kept telling her no - After 7-10 minutes, FS #4 cleaned client #1 and dressed him - Client #1 was quiet the remainder of her time at the facility on 9/1/24 - Left the facility at 4:00 pm on 9/1/24 leaving FS #4 alone with all 5 of the clients from 4:00pm until 11:00pm when staff #3 was scheduled to	V 512		

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V 512	Continued From page 47 arrive - Returned to the facility on 9/2/24 at 7:00 am and reported to staff #2 around 8:00 am the abuse and neglect she witnessed by FS #4 on client #1 the previous day - "Felt defeated and intimidated and didn't know what to do. This man (FS #4) knows where I work and where to find me. But I realized this patient (client #1) can't take care of himself and needs me to speak up for him...Thought about calling after my shift because they were alone with him. Even picked up my phone a couple of times to call [Residential Manager] and put it back down because this just took me to a different mental place. I even thought about calling 911 and requesting a wellness check that night but I didn't" Interview on 9/18/24 staff #2 reported: - On 9/2/24 around 7:30am, staff #1 reported that on 9/1/24, FS #4 "took both hands and grabbed [client #1] and slammed him down on floor. She specified slammed." - Body checks were completed each morning for client #1 upon waking him - 9/2/24 body check revealed 5 new bruises on client #1 - After speaking with staff #1 and completing body check, she immediately notified her supervisor, the Residential Manager Interview on 9/18/24 staff #3 reported: - Arrived at the facility on 9/1/24 at 11:00pm to relieve FS #4 of his weekend shift - FS #4 was in the facility alone with clients #1, #2, #3, #4 and #5 - Staff #1 did not report abuse or neglect to him when she arrived for shift at 7:00am on 9/2/24 - Left the facility on 9/2/24 when staff #2	V 512		

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V 512	Continued From page 48 arrived for her shift and was not aware of the abuse and neglect by FS #4 on client #1 at that time Interview on 9/20/24 FS #4 reported: - Worked with staff #1 on 8/31/24 and 9/1/24 - Staff #1 was shadowing - Typically worked alone on weekends - It was a "regular weekend" - Staff #1 left around 3:00pm on 9/1/24 and he was at the facility alone with all 5 clients until staff #3 came at 11:00pm Interview on 9/18/24 the Residential Manager reported: - Staff #2 notified her of 9/1/24 abuse and neglect by FS #4 on client #1 witnessed by staff #1 on 9/2/24 - Was on vacation and business was closed due to holiday - Staff #1 was new and shadowing FS #4 for the weekend - Staff #1 should have called her immediately when the incident occurred - "I would have gotten him (FS #4) off shift right then." Interview on 9/17/24 the Executive Director reported: - Was aware of "a behavioral altercation that happened in the bathroom where [client #1] received an injury" from FS #4 on 9/1/24 - FS #4 was working and staff #1 was shadowing - Staff #1 reported witnessing the "altercation" and that FS #4 "slung" client #1 to the floor - There were allegations of verbal abuse too - Staff #1 reported the "altercation" to staff #2 on 9/2/24 - Staff #1 "had not had all the training she	V 512		

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V 512	Continued From page 49 needs yet. She should have reported it sooner, the day it happened. But that's something they receive in orientation." Review on 9/25/24 of the Plan of Protection dated 9/25/24 written by the Executive Director revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? - The staff responsible for the abuse/neglect has been terminated 9/5/24. - The Residential Manager has received corrective action 9/23/24 for failure to timely notify protocol. - The QP will receive additional training on abuse/neglect on 9/27/24. - All staff of the home (facility) will receive abuse/neglect by October 4th. - Describe your plans to make sure the above happens. - Executive Director will assure participation in the above trainings, scheduling, and follow through. - This training will be mandatory for: - [QP] - [Staff #1] - [Staff #2] - [Residential Manager] - [Staff #3]" The facility served clients with diagnoses of Cerebral Palsy Unspecified, Generalized Idiopathic Epilepsy and Epileptic Syndromes not intractable without status Epilepticus, Anxiety Disorder Unspecified, Major Depressive Disorder recurrent in full remission, Mild and Moderate Intellectual Disabilities, Unspecified Psychosis not due to substance or known physiological condition, Functional Urinary Incontinence, Intermittent Explosive Disorder, Bipolar Disorder,	V 512		

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V 512	Continued From page 50 Moderate Mental Retardation, History of Alcohol Abuse/Dependence, Traumatic Brain Injury, Essential (Primary) Hypertension, Generalized Edema, Vitamin B12 Deficiency, Anemia due to Intrinsic Factor Deficiency, Other Hyperlipidemia, Disorder of Bone Unspecified, and Gastro-Esophageal Reflux Disorder with Esophagitis without bleed. Client #1 was abused and neglected by FS #4 during the weekend of 8/31/24 and 9/1/24. Staff #1 witnessed FS #4 refusing to use client #1's gait belt and safety chair during transfers, toileting and by leaving client #1 in clothing soiled with urine througout a meal. FS #4 slung client #1 on the bathroom floor from the toilet and left him lying there with his pants and adult incontinence brief around his ankles. FS #4 cursed, spoke harshly and forced client #1 to apologize for making FS #4 angry. Client #1 sustained bruising and a fractured hip from the abuse by FS #4. Client #3 was subjected to abuse by FS #4 when he was spoken to harshly and inappropriately for arriving to breakfast late. Client #3 was fearful of FS #4 and avoided him by secluding himself in his room. Despite the abuse and neglect that staff #1 witnessed througout the weekend, she left FS #4 alone with all clients for approximately 7 hours and did not report the abuse and neglect until the following day. Due to staff #1's failure to report observed abuse and neglect, staff #1 failed to protect all clients in the facility from abuse and neglect. This deficiency constitutes a Type A1 rule violation for serious harm/abuse/neglect and must be corrected within 23 days.	V 512		

Legacy
Human Services,
Inc.

626 S. Garnett Street
P.O. Box 88
Henderson, NC 27536
252-438-6700 Office
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October 14, 2024

Mental Health Licensure and Certification Section

NC Department of Health and Human Services

Division of Health Service Regulation

2718 Mail Service Center

Raleigh, NC 27699-2718

Dear Sir/Madam,

Please find enclosed the plan of correction for the Type A1 Rule Violation, Type B Rule Violation and the standard level deficiencies cited at Roanoke Avenue Group Home, Located at 264 S. Beckford Drive, Henderson, N.C 27536. This is in conjunction with MHL #: 091-117.

You shall find upon return that all deficiencies cited have been addressed globally and the correction has been made prior to the correction date of October 18, 2024. Should you have any questions or concerns, please do not hesitate to contact me at the number provided. We thank you for your feedback and welcome your return.

Sincerely,

Jacinta Johnson

Executive Director

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ACCREDITED

Plan of Correction – Roanoke Ave.

Date of Correction: Type A1 10/18/2024 and Type B 11/9/2024

Deficiency Cited: V108: 27G.0202 (F-I) Personnel Requirements. Based on record review and interview, the facility failed to ensure that newly hired personnel had completed the minimum training required including Orientation, Client Rights and Confidentiality, Client Specific, OSHA/Bloodborne Pathogens, CPR/FA including Heimlich PRIOR to begin to shadow train in the group home.

Provider's Plan for Correction: Legacy Human Services, Inc. will ensure that newly hired staff have completed all required training PRIOR to being allowed in the group home for shadowing purposes. This will ensure that staff who are untrained are never in a situation to be left alone with clients when their training is not completed. Staff hired to work in the home will complete no less than: Orientation including Client Rights, Abuse/Neglect/Exploitation, Confidentiality, PCP/ISP – Client Specifics, OSHA/Infectious Disease, CPR/FA, NCI, and Medication Administration PRIOR to being allowed to be in the group home. This training shall be completed within the first 30 days of hire. All Supervisors will sign an In-service stating their understanding of required training PRIOR to Shadowing. The Human Resources Assistant will ensure that new hire employees read the policies in the New Hire Onboarding packet prior to signing them, accepting responsibility for understanding the policies. This will serve as an added layer of acknowledgement of agency policies and acceptance of such procedures. Residential Managers deviating from this policy will receive corrective action, as occurred during this instance.

Responsible Parties: Direct Support Professionals, Residential Manager, Qualified Professionals, Human Resources Assistant, and Executive Director

Correction Date: 10/18/2024 and ongoing

Deficiency Cited: V109: 27G. 0203. Privileging / Training Professionals. Based on record review and interview, the facility failed to ensure that Qualified Professional Staff demonstrated the knowledge, skills and abilities required by the population served.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that the Qualified Professionals receive additional QP competency training from a former NC DHHS State Surveyor to satisfy QP Competency until such time that privileging requirements are established in N.C. The Executive Director will ensure that the Plan of Protection is completed after any Level II

incident or any allegation of Abuse/Neglect/Exploitation. The QPs will ensure that their supervision plans will be completed with newly hired Direct Support Professionals within 30 days of hire. The QP will conduct Client Specific training within the same first 30 days of hire. The QPs will ensure that their Supervision Plans are readily available for review for all paraprofessional staff. The Executive Director will ensure that when an investigation is completed, that all clients will be interviewed as a part of the process, regardless of their mental capacity, history of being an inaccurate historian, or propensity for misinformation.

Responsible Parties: All Qualified Professionals and Executive Director.

Correction Date: 10/18/2024 and ongoing

Deficiency Cited: V291: 27G . 5603. Supervised Living – Operations. The facility failed to ensure coordination of services for client.

Provider's Plan of Correction: Legacy Human Services, Inc., will ensure that each client receives coordination of services such that communication is passed in a timely manner, and with full disclosure to all parties on the team. Following an Incident, the Incident Report is completed immediately including notification to all parties from the supervisor, RN, QP, Day Placement, guardian, and Executive Director. Any doctor or hospital findings will also be attached. Should that Incident Report involve an allegation of abuse/neglect/exploitation, then the client will be seen by a physician within 24 hours. The ON CALL system will be utilized to notify the chain of command 24/7/365 without exception. Supervisors will be held accountable to respond to ON CALL and follow through with full disclosure to the entire team. Failure to respond to incidents in a timely manner will result in corrective action. The Plans of Protection from 9/25/2024 will be implemented as written, training conducted as outlined, and Incident Reporting System followed through each step including Quality Improvement Committee. Any Residential Manager deviating from this process will receive corrective action, as occurred in this instance.

Responsible Parties: All Staff, Qualified Professionals, and Executive Director

Correction Date: 10/18/2024 and ongoing

Deficiency Cited: V366: 27G .0603 Incident Response Requirements. The facility failed to implement timely Incident Response policy.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that policies governing their response to level III incidents are followed. The Plans of Protection from 9/25/2024 will

be implemented as written, training conducted as outlined, and Incident Reporting System followed through each step including Quality Improvement Committee. The Quality Improvement Committee will ensure that any Level II or III incident is followed by a team meeting within 24 hours. The team will assure that any safety training, timely notification, behavior outburst training, transferring, etc., is reviewed for the clients to reduce the likelihood of further incident. Supervision Plans will be completed as required, made readily available, and include client specific information which is meant to protect clients and ensure safety.

Responsible Parties: Clinical Teams, Qualified Professionals, Quality Improvement Committee, and Executive Director

Correction Date: 10/18/2024 and ongoing

Deficiency Cited: V512: 27G .0304. Protection from Harm, Abuse and Neglect. The facility failed to protect clients from abuse and neglect.

Provider's Plan of Correction: The Plans of Protection from 9/25/2024 will be implemented as written, training conducted as outlined, and Incident Reporting System followed through each step with monitoring provided by the Quality Improvement Committee. All staff of the Roanoke Avenue Group Home will receive additional training on the necessity of timely reporting, full disclosure, and recognizing Abuse/Neglect/Exploitation. The staff responsible for abuse/neglect was terminated during a timely full Investigation completed by the agency and was placed on the health care registry. The agency self-reported to NC IRIS as well as timely notifications to Department of Social Services and local police. The Residential Manager who failed to notify the proper chain of command has received disciplinary action. The newly hired staff who reported late have received all required training, and additional Abuse/Neglect/Exploitation training in addition to timely reporting. All Residential Managers of the agency have also received additional In-Service training on Timely Reporting Procedures.

Responsible Parties: ALL Supervisors, Qualified Professionals, Quality Improvement Committee, and Executive Director

Correction Date: 10/18/2024 and ongoing

Provider Signature: _____ QP / EXECUTIVE DIRECTOR

Division of Health Service Regulation
Mental Health Licensure and Certification Section
(Top portion completed by DHSR staff)

Facility Name: Roanoke Avenue Group Home MHL Number: 091-117

Rule Violation/Tag #/Citation Level: (Administrative Action and Crosses)

10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation / V512 / Type A1

Plan of Protection – Completed by Facility Staff

(Attach additional pages if needed)

What immediate action will the facility take to ensure the safety of the consumers in your care?

- THE STAFF RESPONSIBLE FOR THE ABUSE/NEGLECT HAS BEEN TERMINATED 9/5/2024.
- THE RESIDENTIAL MANAGER HAS RECEIVED CORRECTIVE ACTION 9/23/2024 FOR FAILURE TO TIMELY NOTIFY PROTOCOL.
- THE QP WILL RECEIVE ADDITIONAL TRAINING ON ABUSE/NEGLECT ON 9/27/2024.
- ALL STAFF OF THE HOME WILL RECEIVE ABUSE/NEGLECT BY OCTOBER 4TH.

Describe your plans to make sure the above happens.

- EXECUTIVE DIRECTOR WILL ASSURE PARTICIPATION IN THE ABOVE TRAININGS, SCHEDULING, AND FOLLOW THROUGH.
- THIS TRAINING WILL BE MANDATORY FOR:
  - DOUGLAS GUPTON
  - BACOTE MOYSTEN
  - DERRICK WILLIAMS
  - TAKEASHA SEWARD
  - TIENNA MAGBIE

Facility Staff completing this form:

QP/E.O. 9/25/2024

Name/Title Date

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CITATION LEVEL: Number of days from survey exit for citation correction
Type A = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

Division of Health Service Regulation
Mental Health Licensure and Certification Section
(Top portion completed by DHSR staff)

Facility Name: Roanoke Avenue Group Home MHL Number: 091-117

Rule Violation/Tag #/Citation Level: (Administrative Action and Crosses)

10A NCAC 27G .5603 Supervised Living for Adults with Developmental Disabilities –Operations / V291 / Type B

Plan of Protection – Completed by Facility Staff

(Attach additional pages if needed)

What immediate action will the facility take to ensure the safety of the consumers in your care?

- THE EXECUTIVE DIRECTOR WILL SCHEDULE TRAINING FOR ALL STAFF REGARDING TIMELY REPORTING, DETAILED REPORTING TO ALL RESPONSIBLE CLINICAL PARTIES (QP/RN). REVIEW OF AGENCY POLICY. NO LATER THAN 10/.
- THE RESIDENTIAL MANAGER HAS RECEIVED CORRECTIVE ACTION ON 9/23/2024 FOR FAILURE TO TIMELY NOTIFY.
- THE QP AND RESIDENTIAL MANAGER WILL ASSURE THAT ANY ALLEGATION OF ABUSE/NEGLECT IS FOLLOWED BY HOSPITAL VISIT WITHIN 24 HOURS.

Describe your plans to make sure the above happens.

- THE QA/QI WILL CONTINUE MONTHLY TO REVIEW ALL INCIDENT REPORTS AND ENSURE PROPER AND ADEQUATE COMMUNICATION ~~AND~~ AMONG ALL STAFF AND TEAMS. AS WELL AS FOLLOWING APPROPRIATE PROTOCOL.

Facility Staff completing this form:

[signature] Q.P. / E.D. 9/25/2024

Name/Title Date

CITATION LEVEL: Number of days from survey exit for citation correction
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Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date