STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-071	A. BUILDING: _____ B. WING _____	R 11/20/2024

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on November 20, 2024. Four complaints were substantiated (intake #NC00219360, #NC00221362, #NC00219779 and #NC00222068) and two complaints were unsubstantiated (intake #NC00221124 and #NC00221367). 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 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000	RECEIVED DEC 3 1 2024 DHSR-MH Licensure Sect	
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	V 108	V108 Administrator will in-service Qualified IDD Professional of requirement to train all staff on people supported treatment plans prior to working in the home using Client Specifics forms for documentation. Clinical team will audit each staff file to ensure training is documented. Administrator will monitor new staff training documentation monthly for 90 days and staff training will be monitored ongoing by the Qualified Professional through Clinical Supervision. By 1/19/25	

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V 108	Continued From page 1 .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 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 record reviews and interviews, the facility failed to ensure 11 of 15 current paraprofessional staff (Staff # 2, #4, #6, #8, #10-#15 and the Direct Support Supervisor) were trained to meet the mh/dd/sa needs of the clients as specified in the treatment/habilitation plan. The findings are: Review on 8/6/24, 8/12/24, 8/14/24 and 8/19/24 of the Direct Support Supervisor's record revealed: -Date of Hire: 6/3/21. -No evidence of training to meet the mh/dd/sa needs of Client #1. Review on 8/12/24, 8/14/24 and 8/19/24 of Staff #2's record revealed: -Date of Hire: 7/3/24.	V 108		

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V 108	Continued From page 2 -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #4's record revealed: -Date of Hire: 3/11/24. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #6's record revealed: -Date of Hire: 1/22/24. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #8's record revealed: -Date of Hire: 7/5/17. -Job Title: Direct Support Associate. -No evidence of training to meet the mh/dd/sa needs of Client #1 and Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #10's record revealed: -Date of Hire: 6/25/24. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #11's record revealed: -Date of Hire: 7/16/24. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24	V 108		

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V 108	Continued From page 3 of Staff #12's record revealed: -Date of Hire: 4/29/24. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #13's record revealed: -Date of Hire: 4/28/21. -Job Title: Direct Support Specialist. -No evidence of training to meet the mh/dd/sa needs of Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #14's record revealed: -Date of Hire: 12/1/23. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Review on 8/12/24, 8/14/24, 8/19/24 and 8/20/24 of Staff #15's record revealed: -Date of Hire: 4/2/24. -Job Title: Direct Support Professional. -No evidence of training to meet the mh/dd/sa needs of Client #1, Client #2, or Client #3. Interview on 8/7/24 with the Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator revealed: -Had concerns about facility staff not being trained on client treatment plans. Interview on 8/19/24 with Staff #2 revealed: -Worked alone at the facility, I have never had anybody work with me." -He had not been trained to meet the specific mh/dd/sa needs of the clients at the facility. -" ...I was told [Client #1] has a boyfriend that likes to sneak in and out of the bedroom window	V 108		

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V 108	Continued From page 4 and that's all I was told ...I ...didn't get a heads up that they (clients) like to wander off ...I wasn't told anything about the clients ... Interview on 8/19/24 with Staff #4 revealed: -Worked at the facility once or twice...I worked a day last month (July 2024) and possibly the month before ...I don't know that home (facility). I don't know the details of that home too well." -He worked alone on each shift at the facility. -"I looked into their (clients) files and read information to ...kind of have a ballpark idea on each of them (clients). I didn't really know the new girl, [Client #1], but I had access to the information and ...I was looking at all the information when I was giving the meds (medications and stuff)." Interview on 8/16/24 with Staff #6 revealed: -Assigned to Sister Facility A, "also worked at Sparta Road Home every now and then." -Worked alone when covering shifts at the facility. -Client behaviors were documented in the facility's electronic system, but she had not been trained "necessarily how to handle them (behaviors) ...nobody at RHA (Licensee) sits with us and reviews it." Interview on 8/21/24 with the Direct Support Supervisor revealed: -Staff were required to review all client treatment plans and should have been "trained beforehand, before going into a home (facility) ..." Interview on 8/12/24 with Qualified Professional (QP) #1 revealed: -Documentation of staff training to meet the specific needs of clients, "I have some (documentation). I can give you what I have. My office is a mess. At one point in time they (staff	V 108		

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V 108	Continued From page 5 training documents) were in 1 folder and now they are in individual folders per month. I do the client specific training before staff actually start working with the clients which includes reviewing ...the goals." It could not be determined if all staff training documents had been provided for review during the survey.	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	V 109	V109 The Regional Vice President in-serviced all Qualified Professionals and Administrator on RHA reporting requirements for abuse, neglect, and exploitation investigations. This included 24-hour reporting Health Care Registry, IRIS submission, Department of Social Services and guardian notifications. The Regional Vice President/Quality Assurance Specialist will monitor all investigations to ensure reporting requirements are followed ongoing. Completed 9/18/24	

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V 109	Continued From page 6 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 reviews, observation and interviews, 1 of 1 audited Qualified Professional (QP #1) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: General Statute 131E-256 Health Care Personnel Registry (V132). Based on record reviews and interviews, the facility failed to report all allegations of abuse to the Health Care Personnel Registry (HCPR), including injuries of unknown source, failed to complete the investigation of alleged acts as required, and failed to protect the client from harm pending an investigation. Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on record reviews and interviews, the facility failed to ensure service coordination was maintained between the facility operator and the qualified professionals responsible for treatment/habilitation for 1 of 3 clients (Client #3). Cross Reference: 10A NCAC 27G .0603 Incident	V 109		

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V 109	Continued From page 7 Response Requirements for Category A and B Providers (V366). Based on record reviews, observation and interviews, the facility failed to implement written policies governing their response to level I, II or III incidents. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to report all Level II and III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services are provided within the mandated time frame. Cross Reference: 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions (V500). Based on record reviews and interviews, the facility failed to ensure all instances of alleged abuse were reported to the local Department of Social Services (DSS). Review on 8/6/24 of QP #1's record revealed: -Date of Hire: 6/11/07. -Unsigned, undated job description: " ...uses traditional and innovative approaches to identify effective solutions ...understands and follows company policies ...calls attention to actions that may violate policies and procedures ...Trains and in services direct care staff ...Responsibilities include ...resolving problems ...Directly supervises employees generally consisting of Home Managers ...Nurses ...Conducts and supervises formal investigations into incident/allegations of people supported abuse, neglect, exploitation or other circumstances that may present risk to people supported safety and health. Participates in ...meetings with Local Management Entities (LMEs) ...Assess progress	V 109		

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V 109	Continued From page 8 by completing reviews ...and by recommending changes as appropriate ...Spends time on a regular basis at the location where services are being performed ...including each shift to ensure policy, procedures and program data are in place and being implemented appropriately. Ensures all aspects of the residential activity, including ...adequate staffing, documentation, etc. are operating smoothly ...Reviews and maintains people supported incident reports, charts ..." Interview on 11/20/24 with the Senior Vice President of Operations revealed: -The following modifications were implemented: -Increased staffing at the facility when more than 1 client is present. -Increased monitoring of staff by supervisors and the clinical team. -The clinical team was retrained on protocol of client abuse, neglect and exploitation; investigations; timely reporting to outside agencies; and timely notification to guardians. Review on 9/17/24 of a Plan of Protection completed by the Intellectual Developmental Disability (IDD) Administrator on 9/17/24 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The Regional Vice President will in-service all Qualified Professionals on RHA (Licensee) Reporting Requirements for abuse, neglect, exploitation. This will include 24 hr (hour) reporting to Health Care Registry, IRIS (Incident Response Improvement System) Submission, Department of Social Services and guardian/family by 9/18/2024 at 5pm. Describe your plans to make sure the above happens. The Regional Vice President will in-service all	V 109		

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V 109	Continued From page 9 Qualified Professionals on RHA Reporting Requirements for abuse, neglect, exploitation. This will include 24 hr reporting to Health Care Registry, IRIS Submission, Department of Social Services and guardian/family by 9/18/2024 at 5pm. The Administrator & Regional Vice President or Quality Assurance Specialist will monitor all investigations to ensure reporting requirements are followed timely - ongoing." The facility served 3 clients with diagnoses including, but not limited to, Moderate Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder, Traumatic Brain Injury, Seizure Disorder, Oppositional Defiant Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Schizoaffective Disorder, Obsessive Compulsive Disorder, and Eating Disorder. QP#1 was responsible for clinical oversight of the facility including conducting formal investigations into incidents and allegation of abuse and neglect. On 7/2/24 Client #3 alleged she had been physically abused by Staff #7 during an incident which resulted in Client #3 having moderate-severe head and facial trauma which included a black eye. Client #3 sustained additional facial trauma and a subsequent black eye within less than a week after the first black eye. QP #1 did not seek medical attention for Client #3 from 7/2/24-7/8/24 despite a request for medical evaluation from Client #3's sister. QP#1 was made aware of Client #3's allegation against Staff #7 on 7/2/24 yet failed to investigate or report it. QP#1 did not ensure safety measures were implemented as Staff #7 continued to work at the facility alone with all 3 clients. Between 6/1/24-8/11/24 Client #1 and Client #3 were involved in numerous level I, II and III behavioral incidents. QP #1 failed to ensure the legal guardian was notified of all incidents and also	V 109		

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V 109	Continued From page 10 failed to report the incidents to the Health Care Personnel Registry, Local Management Entity/Managed Care Organizations and Department of Social Services. QP#1 did not investigate or report all incidents of alleged abuse and did not implement protective measures to ensure safety of clients. Incident reporting was not completed as required including completion of a risk/cause analysis to determine the cause of the incidents or assigning individuals to be responsible for implementation of corrective and preventative measures. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and	V 112	V112 The clinical team will review electronic records for goals which include intervention strategies and signed consents via internal chart reviews. When treatment plan changes are made during the year as provided by the Care Coordinator, Qualified Professional will document in the client chart and Administrator will monitor for short term goals and their guardian consents monthly for 90 days. Charts will be monitored through the chart review process. By 1/19/25	

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V 112	Continued From page 11 (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and intervention strategies to meet the individual needs of 2 of 3 clients (Client #1 and Client #2) and failed to obtain written consent or agreement by the legally responsible party for 2 of 3 clients (Client #2 and Client #3). The findings are: Review on 8/5/24 of Client #1's record revealed: -Date of Admission: 6/13/24. -Diagnoses: Moderate Intellectual Developmental Disability; Attention Deficit Hyperactivity Disorder; Anxiety Disorder; Traumatic Brain Injury; Seizure Disorder; Depression. -Psychological Evaluation dated 6/4/24: " ...history of verbal and physical aggression, impulsivity, and unsafe sexual behaviors ...significant difficulty with appropriate boundaries and pro-social skills with the opposite sex and recognizing unsafe behaviors ...at risk of exploitation ...requires significant support and supervision ..." Review on 8/6/24 of Client #1's Treatment Plan dated 5/23/24 revealed:	V 112		

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V 112	Continued From page 12 -" ...[Client #1] has trouble controlling her temper and will be verbally aggressive at times ...[Client #1] will focus on trying to have intimate relationships with individuals who don't have her best interest at heart ...has a history of skin-picking and ...a history of self-injurious behavior ...It's important [Client #1] doesn't have access to a cell phone or internet due to a history of inappropriate usage. She will talk with men and give men her contact information." -No goals/intervention strategies to address verbal and physical aggression, impulsiveness, unsafe sexual behaviors, or self-injurious behaviors. Review on 8/5/24 of Client #2's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Mild Intellectual Developmental Disabilities; Allergic Rhinitis; Constipation; Obesity; Essential Hypertension; Oppositional Defiant Disorder; Seborrheic Dermatitis; Gastro-esophageal Reflux Disease; Major Depressive Disorder; Generalized Anxiety Disorder; Vitamin D Deficiency. -FL-2 dated 6/17/24 revealed: "Injurious to Self ...Injurious to Others ..." Review on 8/6/24 of Client #2's treatment plan dated 1/11/24 revealed: -No goals/intervention strategies to address Client #2's injurious behavior towards self, or others. -No signatures of consent from the legally responsible party. Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder;	V 112		

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	MHL097-071	A. BUILDING: _____ B. WING _____	R 11/20/2024

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V 112	Continued From page 13 Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/6/24 of Client #3's treatment plan dated 7/31/24 revealed: -No signatures of consent from the legally responsible party. Review on 8/6/24 of Client #3's behavioral support plan (BSP) dated 1/20/24 revealed: -No signatures of consent from the legally responsible party. Interview on 8/7/24 with Client #1's and Client #3's legal guardian revealed: -Strategies for behaviors were discussed at treatment team meetings, "but we don't do them after every single incident because there has been so much, and I don't know if I am even being told everything ...There's just so many incidents lately and [Qualified Professional (QP) #1] might be overwhelmed." Interview on 8/8/24 with Client #2's legal guardian revealed: -Received short term goals for Client #2 on an intermittent basis. -Unable to recall the dates he last reviewed the goals. Interview on 8/7/24 with the Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator revealed: -"I always invite [QP #1] to my meetings, and rarely does she show up. She (QP #1) has monthly meetings for behavior support, but I have asked for short term goals and have difficulty getting them ...Long term goals are completed by [LME/MCO] ...but [QP #1] is supposed to do the	V 112		

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V 112	Continued From page 14 short-term goals ...I received a revised plan of short term goals for [Client #3] in March 2024, and I don't have anything for [Client #2] for 2024. I did not receive one for 2023. [Client #3's] plan is supposed to be effective in August each year since her birthday is in July, and I do not have a current short-term plan for her goals either ..." Interview on 8/6/24 with QP #1 revealed: -There were no other documents related to goals/intervention strategies for Client #1. -She did not have a signed treatment plan for Client #2 or Client #3. -Client #2's treatment plan had been sent to the guardian for signature but was not returned. -The treatment plan for Client #3 was just completed on 7/31/24 and had not been signed. -Did not have an explanation as to why the BSP for Client #3 contained no signatures.	V 112		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap	V 115	V 115 Additional staffing was put in place at Sparta Rd home on 9/12/24 with 2 staff (one per person supported) on each shift until 9/18/24 when one person supported was discharged to another provider. The administrator monitored schedule to ensure 2 staff were on each shift each day until 9/18/24. The clinical team completed unannounced drop in visits 2x a week until 9/18/24. Clinical team to complete unannounced visits routinely. Completed 9/25/24	

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V 115	Continued From page 15 are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide supervision to ensure the safety and welfare of 2 of 3 clients (Client #1 and Client #2). The findings are: Review on 8/5/24 and 8/6/24 of Client #1's record revealed: -Date of Admission: 6/13/24. -Diagnoses: Moderate Intellectual Developmental Disability; Attention Deficit Hyperactivity Disorder; Anxiety Disorder; Traumatic Brain Injury; Seizure Disorder; Depression. -Psychological evaluation dated 8/16/23: " ...has a history of ...unsafe sexual behaviors ...has significant difficulty with appropriate boundaries and pro-social skills with the opposite sex and recognizing unsafe behaviors. She is at risk of exploitation ...requires significant support and supervision due to her developmental delays, unsafe behaviors and risk of exploitation ..." Review on 8/5/24 of Client #2's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Mild Intellectual Developmental	V 115		

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V 115	Continued From page 16 Disability; Allergic Rhinitis; Constipation; Obesity; Essential Hypertension; Oppositional Defiant Disorder; Seborrheic Dermatitis; Gastro-esophageal Reflux Disease; Major Depressive Disorder; Generalized Anxiety Disorder; Vitamin D Deficiency. -FL-2 dated 6/17/24: " ...Injurious to Self ...Injurious to Others ...Injurious to Property ..." Review on 9/19/24 of the facility's internal incident reports dated 9/6/24 through 9/12/24 revealed: -9/6/24 at 7:19 pm, reported by Staff #6 regarding Client #1: "Staff discovered a new piercing on upper right cheek. Staff asked client and she said she did it herself ...pierced herself ...Increase monitoring & increase staffing ..." -9/6/24 at 7:19 pm, reported by Staff #6 regarding Client #2: "Staff discovered a new piercing on the right side of his nose, staff asked, and he said he did it himself ...Increase monitoring & increase staffing ..." -9/12/24 at 8:00 am, reported by Staff #6 regarding Client #1: " ...staff discovered a small bruise on the right side of [Client #1's] neck which appeared to be a hickey ...Additional staffing will be put in place until [Client #1] moves ..." -9/12/24 at 8:00 am, reported by Staff #6 regarding Client #2: " ...staff discovered a small bruise on the right side [Client #2's] neck which appeared to be a hickey ...Double staffing put into place until housemate (Client #1) moves to another home (facility) ..." Review on 9/19/24 of a "Mini-Team Report" for Client #1 dated 9/12/24 revealed: -"[Client #1] and her housemate (Client #2) gave each other hickeys ...Additional staffing will be put in place for close monitoring. After interviewing both [Client #1] & her peer (Client #2) it was determined nothing further occurred."	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 115	Continued From page 17 Review on 9/19/24 of a "Mini-Team Report" for Client #2 dated 9/12/24 revealed: -"[Client #2] and his housemate (Client #1) gave each other hickeys ...additional staffing will be put in place for close monitoring. After interviewing both [Client #2] & his peer (Client #1) it was determined nothing further occurred. While being interviewed he told the admin (administrator) that giving each other a hickey was having sex ..." Interviews on 8/7/24 and 9/20/24 with Client #1's guardian revealed: -" ...There has been a lot going on ...There's just been so many behaviors in this home (facility) ...There's just so many incidents lately ..." -" ...[Qualified Professional (QP) #1] told me [Client #1] had pierced her cheek. She did not say who was working at the facility when it happened ...on Wednesday (9/18/24), I did observe 3 hickeys on her (Client #1's) neck which were fading. [QP #1] informed me that when staff went to the bathroom, [Client #1] and [Client #2] had given each other hickeys. I asked how long staff had gone to the bathroom because that was a lot of hickeys ...she (Client #1) spoke more about a previous incident ...and supposedly staff were in the bathroom then too ...There's inappropriate sexual behaviors that I know [Client #1] has had in the past ...she doesn't know sexual boundaries. [QP#1] told me that somebody (unknown) was reporting that [Client #2] and [Client #1] had sex, but [QP #1] didn't think they had sex and that stood out to me because when she explained to me about [Client #3] reporting allegations, she (QP #1) said the same thing (denied the allegation) ...she (QP #1) said they (Client #1 and Client #2) didn't have sex. [Client #1] knows what sex is, and she has had sex, and she is so experienced ...After the hickey situation,	V 115		

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V 115	Continued From page 18 I was told they were going to double staff ...I could see it (sexual relations) happening with me knowing [Client #1] the way I do ...[Client #1] said she was out in the shed having sex, and everyone said [Client #2] really liked [Client #1]. With [Client #1] and her history, sex is something she uses to keep going. It's part of her trauma history. It's something she has always used, and she doesn't look at sex like we do, and she uses it for manipulation. It doesn't matter if it is a male, or female, she will use sex to manipulate ...If they (Licensee) have somebody that has these behaviors, how can they not supervise them? ...I went (9/10/24) to see her (Client #1) and when I got there, she had gone to an appointment to get her birth control changed. I think she has been checked for STDs (sexually transmitted diseases) ..." Interviews on 9/20/24 and 9/24/24 with Client #2's guardian revealed: -Client #2 "pierced his nose with a thumbtack." -QP #1 made him aware of the piercing "a day, or two after it happened." -QP #1 "just said they (staff) didn't see it because he (Client #2) did it in the bathroom." -He could not recall the specific date of the piercing incident. -" ...[QP #1] called me a few days later, about 3 or 4 days after the piercing incident and said [Client #2] and [Client #1] had put hickeys on each other." -QP #1 did not discuss which staff were working at the facility during the incidents which involved the piercings or the hickeys. -"She (QP #1) said workers (staff) had gone to the bathroom when it (hickeys) happened. It was the reason she said it wasn't caught." -" ...[QP #1] made me aware [Client #2] said he had sex, but [QP #1] told me that [Client #2] didn't	V 115		

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V 115	Continued From page 19 know what sex was and both (clients) had their clothes on, and they were just able to kiss." -"We had a treatment team (meeting) last Thursday (9/19/24) with [QP #1], [Vice President (VP) of Operations], and ...[Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator] ..." -" [LME/MCO Care Coordinator] went out there (to the facility) and [Client #2] approached her and told her in detail how he had sex with [Client #1] in a bed without clothes on. [QP #1's] district manager (VP of Operations) denies it ever happened and said [Client #2] denies it ever happened, and that [Client #2] was never in her (Client #1's) room. I asked ...how, if there was an alarm on the bedroom doors, and awake staff, how that could happen? ...the district manager (VP of Operations) ...flatly denied it happened ... [Client #2] ...told [LME/MCO Care Coordinator] it had happened and that they (Client #1 and Client #2) were in a relationship, and he gave details of what sex included ... I asked ...about it (sexual relations) not being noticed by staff and [VP of Operations] said he (Client #2) hadn't been in the other's (Client #1's) room, but it didn't match what he told [LME/MCO Care Coordinator] ...I have concerns about the neglect that went on to allow this to happen and if the staff who are on duty are really paying attention, how did all of this go on? ...If you let [Client #2] talk, he will open up to you and tell you everything. Either he is not telling the folks at RHA (Licensee) the truth, or they are not being forthcoming about what he is telling. [LME/MCO Care Coordinator] said he (Client #2) gave details and RHA said he doesn't know what sex is." -"I have since talked to [Client #2] and he told me 'yes, there was sexual contact,' and he had sex, and it didn't match what RHA had said. At first [QP #1] and [VP of Operations] said they	V 115		

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V 115	Continued From page 20 interviewed him (Client #2) and there was no sex, but when I later asked [VP of Operations] and [QP #1] during the treatment team meeting (9/19/24), they said they would look into it again. I asked how did they (Client #1 and Client #2) get in each other's room with alarms on the doors. [VP of Operations] said [Client #2] was never in her (Client #1's) room yet [Client #2] said he was. By him (Client #2) taking [LME/MCO Care Coordinator] outside and talking to her and telling her about it and then telling me it's been consistent with the same story." Interview on 8/7/24 with the LME/MCO Care Coordinator for Client #2 revealed: -"...concerns have been related to appropriate supervision of the members (clients) by the staff ..." Review on 9/18/24 of an email dated 9/18/24 from LME/MCO Care Coordinator for Client #2 to Division of Health Service Regulation (DHSR) Surveyor revealed: -" ...In regards to member [Client #2] - I was contacted last Thursday (9/12/24) and informed that he and the other resident (Client #1) in the house (facility) had given each other hickey's. [QP #1] reported that during her investigation with [Client #2] he disclosed he had sex with the other resident (Client #1). [QP #1] reported that she determined this to be uncreditable and reported that [Client #2] described having his clothes on the whole time and hugging. I saw [Client #2] at the group home on 9/16 (2024) - he asked to speak to me privately on the carport. He told me about having sex with the other resident (Client #1) and described with detail how he took a glove and cut the thumb out to use as a condom. He described being unclothed and in [Client #1's] bedroom when they had sex while the group	V 115		

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V 115	Continued From page 21 home staff was in the living room. He gave enough detail to convince me he no only knows what sex is but that it has taken place. This is a STARK difference in reports ..." Interview on 9/23/24 with Client #1 at an unlicensed Alternative Family Living (AFL) group home revealed: -She had moved out of Sparta Road Home the previous week. -"I pierced my face at Sparta (facility). I just had a piercing needle. I've had it a long time ...I cleaned it with a alcohol pad and put ice on my cheek and popped it through. I keep it clean." -She also pierced Client #2's nose, "I did. I cleaned it first and did the same thing as my own. I used alcohol and ice. The staff didn't know about it. [Direct Support Supervisor] was working that day. He wasn't paying attention, and we did it (piercings) in the living room. Nobody was watching. [Direct Support Supervisor] went to get something outside. He went outside and stayed outside. We did it in the living room though. We weren't in the bathroom. [Staff #6] found out about the piercings when she came to work. [Staff #6] and [Direct Support Supervisor] told us not to do it again. I was not questioned by anyone except [QP #1]. She asked me why I pierced [Client #2's] nose and asked me not to do it again. [Client #2] is moving to [Sister Facility A], they're getting ready to shut that place (Sparta Road Home) down because they have no staff. When [Staff #6] came to work, [Unknown Staff Member], [Direct Support Supervisor], and [Staff #6] all went outside. They all were outside and smoking. [Client #2] and I were in the living room, and we gave each other hickeys. I gave him a hickey on his neck, and he gave me some on my neck, and on my shoulder, but nowhere else ... [Unknown Staff Member], and [Staff #6] and	V 115		

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V 115	Continued From page 22 [Direct Support Supervisor] asked how we got the hickeys when they saw it. [QP #1] asked too. [QP #1] called me into her office and asked me a bunch of questions about hickeys and piercings. I told the truth. Staff asked about sex and kept on asking. They said we (Client #2 and Client #1) ain't making no babies. Me and [Client #2] had sex in my room. It was just once in my room. [Client #2] came in there with me at night. We were on my bed. [Staff #6] found out because I think she heard me moaning and my bed shook, so [Client #2] got up and went to his own room. The other times, it was in the living room. I didn't tell staff we had sex because they all already knew. Everybody accused us, so we did it anyway. [QP #1] asked me about it and called me and [Client #2] to her office one at a time. We only spoke to [QP #1]. Didn't speak to [Intellectual Developmental Disability (IDD) Administrator] or [VP of Operations]. I told [QP #1] 'yes, it happened. We had sex.' I told her 'yes we did.' She already knew about the hickeys. After we told [QP #1] we had sex, they made it to have 2 staff every night. It made [Client #2] upset because he couldn't see me and get in my bed anymore." Interview on 9/19/24 with Client #2 revealed: -"My housemate (Client #1) put a piercing in my nose. [Client #1] put a piercing in my nose. I'm not in trouble, am I? ...She (Client #1) used alcohol to clean it, and she used a fresh needle out of the pack and soaked the needle in alcohol for 30 minutes or so ...It's been about 2 weeks ago. It was on shift change. I don't remember who was there. I just remember it was shift change. It's been so wild around here lately ... [Client #1], she pierced her own self. She used to be licensed to do that. She owned a tattoo and piercing shop before she moved here. She pierced her eyebrow, and I think she put one in	V 115		

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V 115	Continued From page 23	V 115		

her lip. They (staff), I think, found out. Staff come by the house (facility) and seen it in my nose and questioned us..."
- [QP #1] and [IDD Administrator] and [VP of Operations] asked him about the piercings. "They made me take it (piercing) out. [IDD Administrator] told me to take it out."
-"[Client #1] made one (hickey) on my neck and I made one on her. She wanted me to. We have been boyfriend and girlfriend for 2 or 3 months ...I made the hickey on [Client #1's] neck. It looks like a red mark that stays there for a while. You suck and suck and bite I think because she told me to do it. I think it's gone now. It's gone ...[QP #1] and [QP #3] ...they saw the hickey. They just said 'okay' and that evening they called me in the office and [IDD Administrator] and [QP #1] and [QP #3] was in there and they said I couldn't touch her (Client #1) anymore and that I couldn't be around her, but everywhere I went, she went, so it didn't really do any good."
-He acknowledged having a sexual relationship with Client #1, "It happened when she (Client #1) first moved in. It was about 2-4 weeks after she moved in, and it happened 2 times a couple of weeks ago. [Direct Support Supervisor] was outside in a chair, asleep in the carport and smoking and fell asleep. The first time it happened in the building, in the little workshop (shed) that I got. We fell in love when she first moved there. Staff was inside watching tv (television), it was [Direct Support Supervisor] the same person that was outside asleep. Just [Direct Support Supervisor] was working, and [Client #3] was still living there. I think [Client #3] seen us go out there and she told [Direct Support Supervisor] that [Client #1] and [Client #2] was in the building, and we was done doing what we were doing before he came out there. The other time, she (Client #1) was helping me put

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V 115	Continued From page 24 birdhouses together, and another time in the garden pulling weeds. One day last week, she asked me if I would marry her, and I told her I would ...She felt safe around me and wanted me to spend the rest of my life with her, but I guess we can't now." -Staff were aware he and Client #1 were having a sexual relationship, "I think every time they found out about it. One of the times, [Staff #6] walked in a room and [Client #1] had wanted me to go to her bed in her room and I was in bed together with [Client #1]. She (Staff #6) heard it, I think. She said she didn't care if we done it or not." -"[QP #1], [IDD Administrator] ...I told them we had sex, but they didn't believe we did it. I am telling the truth, and you can ask [Client #1], and she will tell you the same thing. Last week, I told them the truth the same day as telling about the piercing." -After telling staff he had sexual relations with Client #1, changes were made to have 2 staff at the facility for all shifts until Client #1 moved out of the facility. -"My care coordinator came the other day, it was [LME/MCO Care Coordinator] and I went outside and told her that me and [Client #1] was in love with each other and wanted to be together and that we had sex ...I told her they told me it was illegal to do that in a group home. It was [IDD Administrator], and [QP #3], and [QP #1], but [LME/MCO Care Coordinator] said it was not illegal to do it in a group home." -He described sex as "You stick your p***s in her hole or whatever and move up and down and stuff. We had all our clothes off except for our shirts. We was naked down to our feet." He penetrated Client #1 "and moved up and down." Interview on 9/19/24 with QP #1 revealed: -" ...The piercings were discovered by [Staff #6],	V 115		

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V 115	Continued From page 25 so I notified nursing, and then the guardians were notified ... When I talked to [Client #1], it was her cheek that had been pierced. I asked her where she did it. She said the living room and then the bathroom. I told her to take it out and told her and [Client #2] both to take it out. Nursing said clean it with antibiotic ointment and keep an eye on it. I asked her (Client #1) what she did it (piercing) with. She said a needle, and then a thumb tack, so there were inconsistencies there about what she used. [Client #2], his nose was pierced. When I asked him who done it, he said that he did. He said it was in the bathroom at first or might have said the living room the first time and it was back and forth. We talked about his parents and how upset they would be and that I would have to notify them, and he (Client #2) had to take it out. I asked where he got the ring (piercing jewelry) from, and he said [Client #1]. When I asked him what it was pierced with, he said a push pin, which is pretty much a thumb tack. [Client #2] had a piercing on the right side of his nose." -Hickeys on Client #1 and Client #2 "were discovered by [Staff #6], and I had [Staff #6] do incident reports ...It was the 12th (9/12/24) they were discovered. I had them (Client #1 and Client #2) come to the vocational center (9/12/24), and interviewed them separately. [Client #1] said that I asked about the sexual part. I said, 'did you kiss him?'. She said 'yes.' I then asked about the hickeys, and she said 'yes.' I asked if anything else sexual happened and she said 'no' ...He (Client #2) said they 'kissed.' He said they 'gave each other hickeys.' I asked if anything else happened and he said 'well,' they (Client #1 and Client #2) 'had sex'. I said what do you mean, and he said something along the lines of 'you know sex.' I talked with my supervisor [IDD Administrator], and I was in there when she	V 115		

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V 115	Continued From page 26 interviewed him. She asked about the hickeys. He told her he thinks that 'the giving hickeys part is having sex.' We asked about taking clothes off and no clothes came off. At that time, we discussed increased monitoring ...When I notified his (Client #2's) parents (guardians), they were upset. His father said they wanted 1 of them (clients) moved immediately ...The first time he hung up on me ...he was adamant about (clients) moving ...I did tell him at that point there would be a move very soon the following week with the housemate (Client #1) ... after he spoke with [LME/MCO Care Coordinator] he said he would be okay with increased monitoring. I explained we would double staff until we got the other housemate moved ...He was very angry, he was very upset, and the call was short." -When she spoke with Client #1 and Client #2 about sexual relations, "[Client #1] said nothing happened and after [Client #2] was interviewed he said a hickey was having sex and the clothes stayed on, so we increased staffing." Interview on 9/19/24 with Staff #6 revealed: -She discovered piercings on Client #1 and Client #2, "I walked in and discovered it during dinner time that both of them had new piercings. [Client #2] and [Client #1] sat at the table, and I noticed it. I asked when it happened. They said it happened just prior to when I got on shift. [Client #2's], his was the right side of nose and it had a ring in it and [Client #1] had one on the right side of her upper cheek and it was also in an eyebrow. It was a ring with 2 balls. I called the QPs. I called [QP #3] and she told me to call my QP, [QP #1] ... [Client #1] pierced herself and [Client #2] pierced himself is what they both told me. [Client #2] mentioned it wasn't by force, and that he wanted the piercing. The piercing was removed the same day. They were informed to remove it and to	V 115		

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V 115	Continued From page 27 prevent infections." -She also discovered hickeys on Client #1 and Client #2, " ...it was [Client #1's] I had seen because it was more noticeable, and [Client #2] tried to hide his at first and then said 'look ...I have a hickey.' I think this was the day after the piercings. 3rd shift reported it first before I did. I told [QP #1]. I was involved in questions (interviews) about the piercings, but I told that it happened before I was on shift. It could have happened when somebody went to the bathroom. I questioned [Client #1] and she said it was a fake hickey but I had never heard of that and [Client #2] was more scared to tell anything. They didn't admit how they got it (hickey) and just kept putting it off on it being a fake hickey and that she (Client #1) watched a [social media] video of how to make a fake hickey." -She was unaware of Client #1 and Client #2 having sexual relations, "no knowledge at all. My eyes were on them (clients) like hawks. One time I didn't have eyes on them when I was talking to the IT (Information Technology) dude from RHA, but I was still checking in on them (clients) if that makes sense." -She had not observed Client #1 and Client #2 in bed together, "No never. I always saw them in the living room together watching movies and staff was in there with them." -She was interviewed by the IDD Administrator and QP #1 regarding Client #1's and Client #2's sexual relationship, "I told them I didn't know anything about it and when they asked me, it was the first I heard of it." Interview on 9/20/24 with the Direct Support Supervisor revealed: -"I just heard about it (Client #1's and Client #2's piercings) not too long ago. I didn't really know anything about it until recently. I found out when	V 115		

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V 115	Continued From page 28 they were turning in the incident report that they (Client #1 and Client #2) had pierced each other, or that she (Client #1) pierced him (Client #2), or I'm not sure how the incidents happened, but somebody got pierced ...I think at the time it was [Staff #6] that was working." -"I just know that I had seen them (hickeys) when I came into work. I saw them (hickeys) on them (clients). I asked them how it happened. They said that it was her (Client #1's) idea and that it was okay for them to put them (hickeys) on each other. When that particular incident happened, I'm not sure who was working." -"I know he (Client #2) had said something about it (having sexual relations with Client #1), but when he was questioned about actually having sexual intercourse, he couldn't explain it." -He, along with QP #1, QP #3, and the IDD Administrator questioned Client #1 and Client #2 about having sexual relations. Client #1's response was "ask [Client #2]" and Client #2's response was that he 'did it' and then later he said he didn't know what sexual intercourse was. Interview on 9/19/24 with QP #3 revealed: -She saw hickeys on Client #1 and Client #2, " ...I don't know how to characterize if it was 1 big one or a bunch of little ones together. I didn't look closely ..." -She "heard about" a sexual relationship between Client #1 and Client #2, "but when it was looked into, it was not true. What was said in the time frame of what was looked into, there was no way it could have happened ...[Client #2] did not understand what having sex was, what the deed involved was. I was just witnessing (the interviews) for [QP #1] ...He (Client #2) said they were hugging and kissing and that sort of stuff, and not the actual act when asked what it meant to him to have sex."	V 115		

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V 115	Continued From page 29 Interview on 9/19/24 with the IDD Administrator revealed: -" ...She (Client #1) is always looking for love with a girlfriend or a guy friend and it became [Client #2] at some point. We were surprised she talked [Client #2] into piercing his nose. He is usually conservative. She said she did hers and he did his, and we talked to the guardians and his was upset ...they each said they did it themselves ...they wait until the staff are in the restroom or the staff go to bed, or they go into the bathroom themselves and pierce. We know [Client #1] had to provide him (Client #2) with directions, and promoted it, and [Client #2] didn't think of it on his own, so with the few staff we have left, we are really talking to them to be aware all the time. Like if they (clients) are talking quietly or going to the bathroom to be aware." -"Those (hickeys) happened in the living room, and we think it happened when the staff went to the bathroom. We knew what day [Client #1] was transferring to the AFL, and we double staffed. They both said they wanted to kiss, and [Client #2] said she (Client #1) taught him how to give a hickey when sitting in the living room. And every time a staff went out to do something, they attempted to give each other hickeys. [Client #1] changes her story from he (Client #2) knew how to do it, to maybe she told him how to do it ..." -"We talked to [Client #2] about that (sexual relations with Client #1) when it apparently came up when talking to him about the hickey, and I had [Client #2] describe what that (sex) looks like, and he thought a hickey meant sex, and he didn't understand. He showed us hugging, and he hugged on himself and he says that they were hugging. [Client #1] denies the hugging, and says they were just kissing, and she denied everything else. We asked if they were girlfriend and	V 115		

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V 115	Continued From page 30 boyfriend with each other, and she denied it because she talks to numerous girls and guys here, so she won't commit to that. She makes comments to some of the guys from [Sister Facility A] and has to be redirected." Interviews on 9/20/24 and 9/24/24 with the IDD Administrator revealed: -"RHA staffed with the care coordinator (LME/MCO Care Coordinator) yesterday (9/19/24) during a phone call and realized that [Client #2] told the care coordinator a different story of what happened. RHA is doing a repeat full investigation starting today and are already interviewing people." - The LME/MCO Care Coordinator asked if it was possible Client #1 and Client #2 had been left unsupervised. "We did an investigation and they (Client #1 and Client #2) had not been left unsupervised. We have been double staffed" from 9/11/24-9/18/24 when Client #1 moved out of the facility. Review on 9/25/24 of a Plan of Protection completed by the IDD Administrator on 9/25/24 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Additional staffing was put in place in the Sparta Road Group Home on 9/12/24. One staff member was assigned to each person supported (2 staff) per shift for 24 hours until 9/18/24 when [Client #1] was discharged and moved to another provider. On 9/12/24, the Qualified Professional completed an in-service with the staff on one-on-one monitoring (eyes on) for all people supported. The Administrator (IDD Administrator) monitored the daily schedule to ensure 2 staff for each shift were scheduled for the 24-hour period each day until 9/18/24. The clinical team	V 115		

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V 115	Continued From page 31 completed unannounced drop in visits two times a week until 9/18/24. [Client #1] was discharged on 9/18/24. [Client #2] is currently the only person supported living at Sparta Road Group Home. Describe your plans to make sure the above happens. The Administrator (IDD Administrator) monitored the daily schedule to ensure 2 staff for each shift were scheduled for the 24-hour period each day until 9/18/24. The clinical team will complete an unannounced drop in visits routinely. [Client #1] was discharged on 9/18/24. [Client #1] is currently the only person supported living at Sparta Road Group Home." Client #1 and Client #2 had diagnoses including, but not limited to, Mild - Moderate Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Traumatic Brain Injury, Seizure Disorder, Major Depressive Disorder, and Oppositional Defiant Disorder. Client #1 had a history of unsafe sexual behaviors, significant difficulty with appropriate boundaries and pro-social skills with the opposite sex, unsafe behaviors and risk of exploitation, and required significant support and supervision due to her developmental delays. Client #2 had a history of self-injurious behaviors. On 9/6/24, Client #1 pierced a hole in her cheek and inserted a piece of jewelry. On the same day, Client #2 was found to also have a piece of jewelry in his nostril, having pierced the hole and inserted the jewelry himself or having it pierced by Client #1. It could not be determined if the piercings were completed using a piercing needle or a thumbtack. On 9/12/24, Client #1 and Client #2 had given each other hickeys. Client #2 disclosed that he had sexual intercourse with Client #1 more than one time in the facility or on	V 115		

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V 115	Continued From page 32 the facility grounds. Client #2 cut the thumb from a glove to use as a condom. Client #1 acknowledged having sexual intercourse with Client #2 at the facility. During these incidents of piercing, hickeys, and sexual intercourse, staff did not provide Clients #1 and #2 the required supervision. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 115		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is	V 132	V132 Staff remained suspended until conclusion of the investigation. All staff were in-serviced on abuse, neglect, and exploitation reporting procedures on 8/26/24 by the IDD Administrator. Vice President monitored investigations and ensured recommendations were completed. Clinical team completed unannounced visits 2x week for 60 days and monthly going forward. Completed 8/27/24	

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V 132	Continued From page 33 providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all allegations of abuse to the Health Care Personnel Registry (HCPR), including injuries of unknown source, failed to complete the investigation of alleged acts as required, and failed to protect the client from harm pending an investigation for 1 of 3 clients (Client #3). The findings are: Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/27/24 of Client #3's T-Logs dated 6/1/24-8/11/24 revealed: -7/2/24 at 9:27 pm, entered by Staff #7: "[Client #3] ... picked up her chair and threw it at me ...She reared back to strike ...but her hit was blocked causing her to fall ...She landed right on top of her eye ...it caused bruising and swelling ..." Client #3 alleged she had been hit by staff. -7/5/24 at 6:36 pm, entered by Staff #7: Client #3 assaulted Staff #7 and Client #1 in the van. Client #1 and Client #3 began fighting, "they slapped, punched, and scratched each other several	V 132		

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V 132	Continued From page 34 times." -7/31/24 at 8:12 pm: Alleged she was physically abused by a (unidentified) peer and a (unidentified) staff member. Review on 8/5/24 of the facility's internal incident reports for 6/1/24-8/5/24 revealed: -6/22/24 at 12:58 pm reported by Staff #7, "[Client #3] was upset ...calling me the 'n word.' She then picked phone up & dialed 911 requesting they take her out the home (facility)." -On 7/2/24 at 4:40 pm "Location of Incident: Hallway between refrigerator and living room ..." Client #3 " ...attempted to hit staff (Staff #7). When staff blocked the hit [Client #3] turned around and fell. She didn't brace her for the fall and landed face first on the floor ..." Indicate location of injury: An X was marked across the left eye. Type of Injury with options to check boxes for redness, swelling, bruise, scratch, abrasion, etc. had not been filled out and was left blank. Description of the injury and treatment given: No details were documented to describe the injury. Signed by Qualified Professional (QP #1) on 7/5/24. -No reports for incidents on 7/5/24, or 7/31/24. Review on 8/14/24 of an additional internal incident report received from the Intellectual Developmental Disability (IDD) Administrator via email on 8/14/24 at 11:58 am revealed: -On 7/5/24 at 4:30 pm: While in the van Client #3 hit Staff #7, then Client #3 hit Client #1. "Indicate location of injury: " ...Old bruising from prior fall ...Nothing new observed at this time ...No new areas noted ..." No documentation to indicate Client #3 had been physically assaulted by Client #1. No indication that Client #3 received a subsequent black eye during the incident. Signed by QP #1 on 7/8/24.	V 132		

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V 132	Continued From page 35 Review on 8/15/24 and 8/19/24 of an undated photo of Client #3 received by Client #3's sister on 8/14/24 revealed: -Client #3's left eye was closed and swollen. The swelling extended past the bridge of Client #3's nose and was in the shape of an egg. There was bruising of a dark purple color across the entire eyelid, eye socket and surrounding skin below the eye. Review on 8/15/24 of text message correspondence between Client #3's sister and QP #1 revealed: -7/3/24 at 5:34 pm from Client #3's sister: " ...I was informed that [Client #3] had a fall yesterday ...[Client #3] also said that [Staff #7] pushed her and made her fall ...[Client #3] ...was concerned for her safety and wellbeing there (facility) ...I am requesting an investigation in the entire matter ..." -7/3/24 at 7:39 pm from QP #1: Client #3 "isn't telling the full truth to the story. If you want to call me I can explain it. It's a lot easier than texting because it's quite lengthy." Review on 8/14/24 of Provider Notes for Client #3 from an Emergency Department (ED) at a local Medical Center dated 7/9/24 revealed: -"Patient (Client #3) presents to ED from a group home ...according to the staff member at bedside ...There was a fall recently, about 4 days ago (7/5/24) where the patient sustained facial and head injury ...He (Direct Support Supervisor) indicates that the patient has been yelling at her roommate but there has been no physical altercation ..." -"Left facial hematoma noted ...Subconjunctival hemorrhage noted to the left eye from the 2:00 around to the 8 o'clock position ..." -Computed Tomography (CT) scan of head	V 132		

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V 132	Continued From page 36 indicated for "Head trauma, moderate-severe ...No evidence of fracture ...Soft tissue swelling/hematoma over the lateral left frontal bone ..." -CT scan of facial bones indicated for "facial trauma - left periorbital ...Soft tissue swelling seen in the left supraorbital region with small lateral left supraorbital soft tissue swelling/scalp hematoma ..." Review on 8/14/24 of the Computer Aided Dispatch System (CAD) reports from the local Sheriff's Office revealed: -7/9/24 at 3:17 pm Staff #7 called the Sheriff's Office because Client #3 had eloped from the facility. -7/19/24 at 2:06 pm "Call Type Abuse/Abandonment/Neglect ...Comment: Abuse of disabled person." Interview on 8/14/24 with the local County Sheriff's Sergeant revealed: -A Lieutenant from the Sheriff's Office responded to an incident at the facility on 7/9/24. -On 7/9/24, Client #3 told the Lieutenant that somebody at the group home had hit her. -Social workers were at the facility on 7/9/24 and said there was no abuse or neglect. -On 7/19/24, or somewhere around that time the Sheriff's Office received a report alleging abuse/neglect of a disabled person. -He spoke with a Department of Social Services worker, and "she described the exact same thing that our Lieutenant had dealt with on the 9th (7/9/24)..." -The report was "closed out" on 7/24/24. Review on 8/14/24 of an Incident/Investigation Report from the local Sheriff's Office dated 7/16/24 revealed:	V 132		

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V 132	Continued From page 37 -" ...Crime/Incident ...Simple Assault ...Victim ... [Client #3] ...Suspect ...[Staff #7] ...Narrative: On July 16th, 2024, I (Sheriff's Sergeant) received this case from [Local County] Department of Social Services about [Client #3] possibly being assaulted and neglected by her caretaker at the RHA (Licensee) Home. According to the DSS Report ...concerns about her treatment in the RHA house ...[Client #3] had two black eyes within a week of each other ...there was conflicting reports of how she received the black eye ...I contacted DSS worker ...who is working this case to speak with her about it. [DSS worker] said ...officer came to the scene that day (7/9/24) and conducted an investigation. I (Sheriff's Sergeant) contacted [Sheriff's Lieutenant (Lt.)] who was the officer that responded to the scene that evening on July 7th, 2024, and he told me that [Client #3] seemed to be taken care of. Below is [Lt's] statement about the incident: On 07/09/2024 at 1521 (3:21 pm) hours, I received a call to respond to the RHA group home ...in reference to one of the residents, [Client #3], leaving the residence and possibly going to [local store]. Upon arrival, I found that [Client #3] had returned to the residence and she was speaking with staff and adult protective services ...I spoke with [Client #3] and she was noticeably upset ...I did observe [Client #3] to have bruising around her eyes and nose. When asked about what happened, [Client #3] advised she was struck by the other intellectually disabled female subject who lived at the residence ..." Review on 8/7/24 of the North Carolina Incident Response Improvement System (IRIS) for 6/1/24-8/7/24 revealed: -No reports for incidents which involved Client #3's allegations on 7/2/24, or 7/31/24 had been submitted.	V 132		

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V 132	Continued From page 38 -No evidence that allegations made by Client #3 were investigated. -No evidence that plans of prevention/reoccurrence were made by the Licensee to protect clients from harm. -No evidence of how Client #3 sustained a subsequent black eye after she received the first one on 7/2/24. Review on 9/9/24 of documents enclosed in a folder labeled "Sparta Rd. (Road) (facility) August 2024 Investigation" received from the Licensee on 9/9/24 revealed: -An unsigned handwritten document titled Interview with Client #1 8/27/24: - Question: "Have you ever seen anyone put their hands on [Client 3]?" -Response: "[Staff #7]" -Statement: "[Client #3] got upset and tried to throw a chair @ (at) [Staff #7] and [Staff #7] pushed [Client #3] from the back causing [Client #3] to trip. [Client #3] fell & hit her head at the edge of fridge. Did not report when asked previously b/c (because) [Staff #7] told her (Client #1) & [Client #2] not to say anything so she wouldn't get in trouble & that [Client #3] tripped. 'look you tripped over your own two feet you old b***h.' [Staff #7] usually sits on her phone all day claims she goes out to the car & comes back in smelling like weed ..." -A typed document with the following: -"Convening Authority: [IDD Administrator]" -Investigator: QP #2 and Quality Assurance Specialist -"Investigation Type: Physical Abuse" -"In the case of: [Client #3]" -"Investigation Start Date: 08/27/2024" -"Completion Date: 08/31/2024" -"Facts &/or Summary of Evidence: On 08/27/2024, [Client #1] reported to [QP #2] that	V 132		

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V 132	Continued From page 39 she had witnessed [Staff #7] push [Client #3] in the back on 07/02/2024 causing her to fall and get a black eye ... During an initial interview with [Client #2], he stated that he had witnessed [Staff #7] push [Client #3] , causing her to trip and fall. He also stated that [Staff #7] called [Client #3] a 'cracker' and told her that it 'takes an N word to know an N word.' In a written statement from [QP #1], she wrote that ...[Client #3] had initially told [QP #1] that [Staff #7] had hit her and that she wanted her to be fired ...[QP #1] said a couple minutes later she asked [Client #3] again what happened with [Staff #7] and [Client #3] told her ...that [Staff #7] pushed her down ...after that staff called for nursing for permission to give [Client #3] her PRN (as needed) medication for behaviors. After [Client #3] was able to calm down ...[Client #3] said ...she fell. [QP #1] was on the phone with [Client #3] for approximately 1 hour ...During an interview with [Unaudited Day Support Staff] she stated that ...[Client #1] and [Client #2] had been conversing about [Staff #7] physically pushing [Client #3] and causing her to fall prior to [Client #2] being interviewed. During a second interview with [Client #2] he stated that [Client #3] tripped over [Staff #7's] feet ..." Interview on 9/11/24 with Client #3 revealed: -" ...[Staff #7] got mad at me, and I don't know why. She came over to me towards the refrigerator and she threw me on the floor near the refrigerator and my eye was swollen shut and I couldn't see at all. [Staff #7] started it. I didn't do nothing. But they keep hitting me and abusing me and I'm not going back ..." Interview on 8/15/24 with Client #3's sister revealed: -Client #3 "has complained so much about staff calling her names. She has called them names	V 132		

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V 132	Continued From page 40 and used the N word which should not have happened and I'm sure some staff have taken it personal what she has called them, but once you call somebody those names people don't take too kindly to that and people then tend to feed off each other. I don't feel like she is in good hands there (facility). She says they laugh at her and they call her names ..." -On 7/2/24, Staff #7 and Client #3 had "some kind of altercation" resulting in Client #3 having a black eye. -Client #3 reported she had been hit by Staff #7. -Client #3's "eye was so swollen, and she couldn't see out of it." -Client #3 received an additional black eye during the incident (7/5/24) on the van with Staff #7 and Client #1. -When she spoke to Client #3 on 7/6/24, "she (Client #3) sounded so bad ... [Client #3] was concerned for her safety and wellbeing there (facility). I requested an investigation. [Client #3] claimed [Staff #7] pushed her." Interview on 8/7/24 with Client #3's guardian revealed: -Two separate incidents resulted in Client #3 having two black eyes. -She saw photos of Client #3 with the black eyes and "they were God awful. They were in different stages of healing." -Client #3 received the first black eye on 7/2/24, and "within a short period of time" received a second black eye during an incident in the van. -Staff #7 was working at the facility and involved in an altercation with Client #3 during both incidents. Interview on 8/7/24 with the Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator revealed:	V 132		

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V 132	Continued From page 41 -"I have two members that live in that home (facility), [Client #3] and [Client #2] ...I was monitoring [Client #2] in the community around the July 4th (2024) holiday, and I saw a picture of [Client #3] with black eyes ...When I visited the facility, there were conflicting stories of how the black eyes were obtained. One story was that she (Client #3) hit a female resident (Client #1) and then she was hit back. I was told the second black eye was that she (Client #3) ran and fell, and another was she was trying to hit staff (Staff #7). I just don't know what really happened." Interview on 8/15/24 with Staff #7 revealed: -She worked alone at the facility for both incidents in which Client #3 sustained a black eye. -Client #3 sustained the first black eye on 7/2/24 " ...I want to say that one was her left eye ...She (Client #3) ...was going to hit me and ...she immediately turned ...stumbled and landed right on her face ..." -"She (Client #3) said I choked her and all kinds of stuff." -She denied making any type of physical contact with Client #3 during the 7/2/24 altercation. -She was aware allegations were made against her "as soon as it (7/2/24 incident) happened. I heard from other staff that I was stealing her (Client #3's) belongings, and that I choked her, and that I hit her. I can't recall whom, but this is what my coworkers would tell me is being said ...I spoke with [Qualified Professional (QP) #1] and DSS came around, but they never spoke to me ..." -The second incident which resulted in Client #3 having another black eye, occurred on a Friday in July 2024, but she could not recall the specific date. -During the second incident, she was driving a van and Client #3 struck her from behind while	V 132		

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V 132	Continued From page 42 the van was in motion. Client #3 and Client #1 began fighting and "were throwing punches at each other's face." Interview on 8/13/24 with QP #1 revealed: -Client #3 had 2 black eyes. "The first one was during the behavioral incident that took place (7/2/24) ...It would have been when [Staff #7] was working ...She (Client #3) threw a chair and went to hit [Staff #7] and [Staff #7] put her arm up to block and [Client #3] turned around and she fell ...after the incident she spoke to me on the phone. She (Client #3) initially told me staff had hit her. She said it was [Staff #7] ...before I got off the phone with her, she said she fell and that she hadn't told the truth about it and that she went to hit [Staff #7] and got tripped up and she had fell ...I was on the phone with [Client #3] for close to an hour ..." -When asked about the protocol for reporting allegations, she responded, "It needs to be reported immediately if there is suspicion of abuse, or neglect and suspend the staff until what happened can be determined ...Like with [Client #3], she is verbal and able to tell what happened with everything." -In response to what was considered suspicion, she replied, "Any bruising, anything like that or verbal. But [Client #3] has made false allegations, and I asked her multiple times, and she wasn't around staff when I was talking to her (on the phone) so she wasn't being influenced." -Client #3's allegation on 7/2/24 was not reported, or investigated "because I had talked to [Client #3] and when she first said [Staff #7] hit her and when I continued to talk to her, she said she got turned around and got tripped up and she does have a history of false reporting and I asked her multiple times before I got off the phone with her, what happened."	V 132		

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V 132	Continued From page 43 -When questioned about how Client #3 received a second black eye, she responded, "That was [Client #1]. That was the van incident (7/5/24) ..." -In response to being asked if there were any other documents regarding the incidents for the past 3 months such as internal investigations, she replied "No, there was only 1 official investigation (8/4/24 elopements) and everything about the incidents are in the reports. There's nothing else." Interview on 8/26/24 with the Vice President of Operations revealed: -"We (Licensee) are following our procedures ...we are doing an investigation ...If we are doing an investigation, how are we failing to protect...We became aware of this yesterday when [Client #3's] sister requested to speak with the administrator (IDD Administrator). Is it your practice to interview disgruntled staff that have been gone 4 months to a year?" This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
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	V 291	V291 (Cross referenced V109) The Regional Vice President in-serviced all Qualified Professionals and Administrator on RHA reporting requirements for abuse, neglect, and exploitation investigations. This included 24-hour reporting Health Care Registry, IRIS submission, Department of Social Services and guardian notifications. The Regional Vice President/Quality Assurance Specialist will monitor all investigations to ensure reporting requirements are followed ongoing. Completed 9/18/24	

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V 291	Continued From page 44 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 reviews and interviews, the facility failed to ensure service coordination was maintained between the facility operator and the qualified professionals responsible for treatment/habilitation for 2 of 3 clients (Client #1 and Client #3). The findings are: Review on 8/5/24 and 8/6/24 of Client #1's record revealed: -Date of Admission: 6/13/24. -Diagnoses: Moderate Intellectual Developmental Disability; Attention Deficit Hyperactivity Disorder; Anxiety Disorder; Traumatic Brain Injury; Seizure Disorder; Depression.	V 291		

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V 291	Continued From page 45 Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/27/24 of Client #1's T-Logs dated 6/18/24-8/11/24 revealed: -6/18/24 2nd shift: Began picking fights with Client #3 which required staff to separate clients. -6/28/24 2nd shift: Picked a fight with Client #3. -7/2/24 2nd shift: Provoked Client #3 "by withholding guardian's phone number and using unnecessary eye contact to pester her." -7/5/24 2nd shift: Had a physical altercation with Client #3 in the van. -7/21/24 3rd shift: Repeatedly redirected by staff to follow rules, tripped and fell on her knees and side. -7/24/24 1st shift: Altercation on the van with Client #A5. -7/26/24 1st shift: Was assaulted by an unidentified male peer and she pushed him back onto a table. -7/26/24 2nd shift: Informed staff that she has been letting a male come through her window to have sex at night. -7/27/24 2nd shift: Refused to go to her room or to bed, stood around on the carport and back porch looking for an unidentified male peer; was reminded that she could not have company. -7/28/24 7pm-11pm: Was "obsessing over the neighbor and calling him her boyfriend. She was redirected away from the subject several times ..." Review on 8/5/24 of the facility's internal incident	V 291		

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V 291	Continued From page 46 reports involving Client #1 for 6/1/24 through 8/5/24 revealed: -No evidence of notification to the legal guardian for incidents on 6/18/24, 6/28/24, 7/2/24, 7/5/24, 7/21/24, 7/24/24, 7/26/24 1st shift, 7/26/24 2nd shift, 7/27/24, 7/28/24, or 8/4/24. Review on 8/27/24 of Client #3's T-Logs dated 6/1/24-8/11/24 revealed: -6/5/24 at 11:07 am: Broke into the refrigerator, used profanity towards staff, called staff racial slurs and tried to run away. -6/5/24 at 10:24 pm: Used profanity towards staff, attempted to assault Staff #7. Yelled, cussed and slammed doors throughout the facility, hit an unidentified staff member in the mouth and busted the lip of the unidentified staff. -6/11/24 at 8:21 pm: After recently getting caught smoking in her room, was found to have an empty pack of cigarettes, a lighter, and two ash-covered soda cans on her dresser. -6/23/24 at 2:56 pm: Refused to clean her room and was yelling and cussing at staff "for about 2 hrs (hours)." -7/5/24 at 6:36 pm: Assaulted Staff #7 and struck Client #1 in the face which resulted in Client #1 and Client #3 slapping, punching and scratching each other several times. -7/6/24 at 7:09 pm: Antagonized Client #1, screamed, cursed and cried for 30 minutes. -7/9/24 at 6:29 am: Made a mess in the bathroom, stopped up the toilet, and flushed the toilet making it overflow, became angry and cussed staff. -7/10/24 at 3:13 pm: Client #3 was "having a behavior over a prn (as needed medication)." -7/10/24 at 10:17 pm: Client #3 yelled at and called Client #2 names, "slings her plate and cup" at an unidentified client. -7/26/24 at 8:51 am: Vaped in the facility	V 291		

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V 291	Continued From page 47 bathroom with Client #1, left urine and feces on the bathroom floor, used inappropriate language and slurs with staff, eloped from the facility, and appeared to have a medical condition requiring staff to notify nursing. -7/28/24 at 10:52 pm: Pushed her way into the pantry, was defiant, interrupted staff when speaking, stood in staff's way and refused to move. -7/31/24 at 8:12 pm: Made allegation that she was beat with a belt by a client and hit by a staff member. -8/5/24 at 7:01 am: Yelled and used profanity in her room, claimed a client cursed at her. Review on 8/5/24 of the facility's internal incident reports involving Client #3 for 6/1/24 through 8/5/24 revealed: -6/7/24 at 5:30 pm - eloped from the facility - no notification to the legal guardian - report completed by Qualified Professional (QP) #1 on 6/10/24. -6/22/24 at 12:58 pm - vulgar towards staff, threw the housephone, and called 911 - guardian notified by QP#1 on 6/25/24 at 3:00 pm. -6/30/24 at 7:40 pm - Heimlich maneuver for choking - legal guardian notified by QP#1 on 7/3/24 at 1:29 pm. -7/2/24 at 4:40 pm - altercation with Staff #7 which resulted in an injury to Client #3's left eye - legal guardian notified by QP#1 on 7/2/24 at 5:43 pm. -No incident reports for 6/5/24 11:07 am, 6/5/24 10:24 pm, 6/11/24, 6/23/24, 7/5/24, 7/6/24, 7/9/24, 7/10/24 at 3:13 pm, 7/10/24 at 10:17 pm, 7/26/24, 7/28/24, 7/31/24, or 8/4/24 and no evidence of notification to the legal guardian. Review on 8/14/24 of an additional internal incident report received from the Intellectual	V 291		

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V 291	Continued From page 48 Developmental Disability (IDD) Administrator via email on 8/14/24 at 11:58 am revealed: -On 7/5/24 at 4:30 pm: Client #3 hit Staff #7 and Client #1 while on the van. -No documentation to indicate Client #3 had been slapped, scratched or punched by Client #1. -No documentation to indicate Client #3 received a subsequent black eye, " ...has old bruising from prior fall. No new areas noted ..." -Notification to the legal guardian documented by QP #1 as 7/7/24 at 1:00 pm. Review on 8/15/24 and 8/19/24 of an undated photo of Client #3 received by Client #3's sister on 8/14/24 revealed: -Client #3's left eye was closed and swollen. The swelling extended past the bridge of Client #3's nose and was in the shape of an egg. There was bruising of a dark purple color across the entire eyelid, eye socket and surrounding skin below the eye. Review on 8/15/24 of text message correspondence between Client #3's sister and QP #1 revealed: -7/3/24 at 5:34 pm from Client #3's sister: "Hey. I was informed that [Client #3] had a fall yesterday ...[Client #3] sounds awful! I wish she would have an xray on her face to make sure she does not have a fracture especially the eye socket. She said she didn't know how she could see out of her eye and in a lot of pain ...I know how [Client #3] can be, but she is hurt ...She needs medical attention from a professional ..." -7/3/24 between 5:34 pm and 7:39 pm was a response from QP#1, "I was on the phone yesterday with [Client #3] for close to an hour ...I've talked to everyone in the house (facility) and ...(Client #3) isn't telling the full truth to the story. If you want to call me I can explain it. It's a	V 291		

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V 291	Continued From page 49 lot easier than texting because it's quite lengthy ..." Review on 8/14/24 of Provider Notes for Client #3 from a Radiology Department at a local Medical Center dated 7/8/24 revealed: -"Diagnoses: Blunt trauma of face, initial encounter ...X-Ray Sinuses ...Indication: Unspecified injury of face ...Findings: No evidence of acute sinusitis or mass. Normal sinuses." Review on 8/14/24 of Provider Notes for Client #3 from an Emergency Department (ED) at a local Medical Center dated 7/9/24 revealed: -" ...Chief Complaint Patient (Client #3) presents with Altered Mental Status ...Patient presents to ED from a group home because of change in behavior ...according to the staff member at bedside ...There was a fall recently, about 4 days ago (7/5/24) where the patient sustained facial and head injury ...He (Direct Support Supervisor) indicates that the patient has been yelling at her roommate but there has been no physical altercation ..." -"Left facial hematoma noted ...Subconjunctival hemorrhage noted to the left eye from the 2:00 around to the 8 o'clock position ..." -Computed Tomography (CT) scan of head indicated for "Head trauma, moderate-severe ...No evidence of fracture ...Soft tissue swelling/hematoma over the lateral left frontal bone ..." -CT scan of facial bones indicated for "facial trauma - left periorbital ...Soft tissue swelling seen in the left supraorbital region with small lateral left supraorbital soft tissue swelling/scalp hematoma ..." Interview on 8/15/24 with Client #3's sister	V 291		

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V 291	Continued From page 50 revealed: -On 7/2/24 "there was some kind of altercation" with Client #3 and Staff #7. Client #3's eye was injured. -" ...I only found out that [Client #3] had a black eye because of a photo being sent ..." -" I had texted [QP #1] about [Client #3] on Wednesday July 3rd (2024) because I was informed [Client #3] had a fall on July 2nd (2024) and I wish [Client #3] could have an x-ray because her eye was so swollen, and she couldn't see out of it. Then when I spoke to [Client #3] on Saturday July 6th (2024), she sounded so bad, but they (Licensee) wouldn't set up a phone call meeting (treatment team meeting) until Monday July 8th (2024) because it was the 4th of July holiday ..." -On 7/8/24 " ...I was on a 3-way call with [QP #1] and [Client #3's Guardian] ...and [Client #3's Guardian] had not even been made aware of the injury. I remember the date clearly ...[QP #1] said the nurse had seen [Client #3] and I said, 'I don't care because the nurse can't see inside and see if there's internal damage.' [QP #1] was trying to find her log and couldn't find it of where she notified [Client #3's guardian]. [Client #3's] guardian was saying she hadn't been notified and didn't know about the injury and [QP #1] said she logged where she had notified her, but she couldn't find it. [Client #3's guardian] absolutely wanted [Client #3] to be evaluated, and so did I and we both told this to [QP #1]. [Client #3] was checked after the Heimlich was performed, but she wasn't checked after the head injury. We didn't understand why [QP #1] was saying there wasn't a protocol to be checked for a head injury ...the evening after the 3-way call, [QP #1] brought [Client #3] to the hospital to try and have her IVC'd (Involuntarily Committed) ..."	V 291		

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V 291	Continued From page 51 Interview on 8/7/24 with the legal guardian for Client #1 and Client #3 revealed: -"I am aware of (Client #3's) 2 black eyes both were in such a short time period of 2 similar incidents that I am aware of now. I wasn't originally aware of it when it happened. After I had a conversation with a care coordinator, she had mentioned that both [Client #3's] eyes were black, so I was made aware of it after the fact. [QP #1] claimed that she told me, and I have a really good memory and didn't recall being notified. I only found out about the black eyes from the care coordinator. She (Client #3) did not have medical attention on that day, but she did have a scan ordered later (7/8/24) which did come back clear, but I wasn't notified about it when it happened. I would have wanted it done sooner, that's usual protocol if someone hits their head. The pictures that I did see, after the fact, were taken by a family member and they were God awful. They were in different stages of healing, and they are still on my phone. The only way the care coordinator knew about the black eyes was a staff member named [Staff #8] showed her a photo of it on her phone ...I didn't see them on her phone. I only saw the ones taken by a family member which were sent to me last Tuesday (7/30/24) of [Client #3's] eye in the healing stage. There has been a lot going on and [QP #1] has not notified me of a lot of stuff in real time. There's just been so many behaviors in this home (facility) and there's probably a lot that I don't know. There was an incident I believe on June 30th (2024) which was a Sunday and when [Client #3] was taking her medicine, they did the Heimlich maneuver, and they said they took her for an evaluation afterwards, but I wasn't notified until July 3rd (2024), and at that time I was also notified that [Client #3] had went AWOL ...on July 2nd (2024) ...and that was the day she got the	V 291		

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V 291	Continued From page 52 black eye ... There was also an incident when [Client #3] was hitting [Staff #7] while [Staff #7] was driving the van. After she hit [Staff #7] she (Client #3) turned around and hit [Client #1] and [Client #1] punched her back and that's the reason they said she had the other black eye, but I couldn't tell you a date ...I was given behavior data ...it was a book full, there was so much ...It was called T-logs. They (staff) do online documentation, but they have issues with staff not entering it all and [QP #1] said she had done in service with staff about it ...[QP #1] claimed a meeting was held on July 17th (2024) for staff documentation ...I don't know if I am even being told everything ...There's just so many incidents lately and [QP #1] might be overwhelmed." Interview on 8/7/24 with the Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator revealed: -"...It's been really difficult for me to collaborate with [QP #1]. I don't get responses to my emails, or phone calls. I have 2 members that live in that home, [Client #3] and [Client #2]. I always invite [QP #1] to my meetings, and rarely does she show up. She (QP #1) has monthly meetings for behavior support, but I have asked for short term goals and have difficulty getting them ...[QP #1] is supposed to do the short-term goals ...I was monitoring [Client #2] in the community around the July 4th holiday, and I saw a picture of [Client #3] with black eyes. [QP #1] had not informed me about this, and I reached out to her guardian, and she was not aware of the black eyes either. When I visited the facility, there were conflicting stories of how the black eyes were obtained. One story was that she (Client #3) hit a female resident and then she was hit back. I was told the second black eye was that she ran and fell, and another was she was trying to hit a staff. I just	V 291		

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V 291	Continued From page 53 don't know what really happened. I am not informed of many behavior incidents. I received a text yesterday from [QP #1] that there had been an elopement with [Client #3] yesterday and she said she would follow up with an email and I have not received anything. We review behavior reports, but it's always a month behind. I have not been able to review July (2024) behaviors as of yet. [Client #3] ...has GI (gastrointestinal) complaints of diarrhea and nausea and hasn't had a colonoscopy in 10 years. We were told she was referred to a GI doctor in [local county], but RHA (Licensee) manages the medical care coordination, and it's difficult getting answers and having questions addressed. This has been pretty typical with the lack of communication with RHA. There seems to be something going on all the time with [Client #3] at the group home, and if I don't speak with the guardian all the time, I won't really know what is going on with her ...The guardian and I were unaware of [Client #3's] increased behaviors, but when I was on the phone with [Client #2's] parents (guardians), they informed me that one of the residents (Client #3) had been throwing items in the home and gave me some insight about the dysfunction of the home (facility). That was back in June (2024) ...There have been incidents in the vehicle. I suggested that RHA request a higher rate for more staff, and they informed me they can't do that because their staff do not document adequately in the system to have evidence of behaviors and it's a poorly managed situation." Interview on 8/19/24 with Staff #2 revealed: -On 8/4/24 at approximately 10:30 pm, Client #1 and Client #3 eloped from the facility. Client #1 and Client #3 were gone "15 minutes at the most." Later, an unidentified male arrived at the facility and Client #1 and Client #3 were in his	V 291		

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V 291	Continued From page 54 vehicle. -The unidentified male pinched Client #3's arm and said, 'look how dehydrated she is, how come you guys (staff) aren't giving them (clients) enough to drink?" -He reported the incident to QP #1. Interview on 8/15/24 with Staff #5 revealed: -Client #3's black eye "may have happened after I worked there because her eye was black the day after her (Client #3's) birthday (7/14) ..." Interview on 8/15/24 with Staff #1 revealed: -Client #3's "eyes were black, swollen and her nose was swollen across the bridge and her eye actually had blood spots in them and it was pretty nasty." Interview on 8/16/24 with Staff #6 revealed: -She did not observe Client #3 with black eyes. She worked "on and off" at the facility since July 2024, "but never really paid attention to her eye like that. She (Client #3) said one time that it was hurting, but I never saw the injury of the eye ...She told me it hurt. That's the only thing she had said. She didn't say nothing else." Interview on 8/21/24 with the Direct Support Supervisor revealed: -Client #3 had a black eye "a while back ...I wasn't there when it happened, but I came directly after. I was contacted by [Staff #7] ...she (Client #3) said [Client #1] gave her a black eye, but she had the black eye before [Client #1] got admitted (6/13/24)." -There was only 1 incident of Client #3 having a black eye. Interview on 8/13/24 with QP #1 revealed: -Client #3 sustained a black eye during an	V 291		

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V 291	Continued From page 55 incident on 7/2/24. She saw Client #3 on 7/3/24, "her eye turned black. She refused to go get checked out (evaluated) ...She (Client #3) was sent for an x-ray, but the nurses would have the date. I don't have an exact date." -Client #3 sustained a subsequent injury causing a black eye to her other eye during a separate incident in the van, but she did not recall the date of the incident, the date Client #3 was evaluated after the incident, and she could not locate the related incident report. -The x-ray on 7/8/24 for "blunt trauma of face" was not for the black eye Client #3 received during the altercation in the van. "That was for when she fell" on 7/2/24. -The delay in treatment was because Client #3 "refused to go get it checked out. If someone falls, we don't always send them out (for medical evaluation) for falls unless there is obvious fractures, or something in their history. The next day she (Client #3) refused and then we were finally able to talk her into going." -Client #3 went to the Emergency Room (ER) on 7/9/24 for a behavior incident, " ...She was yelling and cursing. That day DSS (Department of Social Services) had come out and I think [Client #3's] sister called about concerns with [Client #3's] eye and I had explained to her about the eye and [DSS Caseworker] came to talk to [Client #3] and when I got there, she (DSS Caseworker) was outside with [Client #3] ...I talked to [DSS Caseworker] and explained to her that we had just met on July 7th (Sunday 7/7/24) and had a plan to do the ER for evaluation, so I went ahead and called [Direct Support Supervisor] to transport her (Client #3) to the ER. -Documents were uploaded into an electronic system "after they are done. " The mini-team reports dated 7/7/24 for Client #1 and Client #3, "I don't have signatures on it yet."	V 291		

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V 291	Continued From page 56 -"I feel like I got stuff. I have documents and I'm trying to get it all organized." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 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 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	V 366	V366 (Cross referenced V109) The Regional Vice President in-serviced all Qualified Professionals and Administrator on RHA reporting requirements for abuse, neglect, and exploitation investigations. This included 24-hour reporting Health Care Registry, IRIS submission, Department of Social Services and guardian notifications. The Regional Vice President/Quality Assurance Specialist will monitor all investigations to ensure reporting requirements are followed ongoing. Completed 9/18/24	

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V 366	Continued From page 57 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, if different; and (D) issue a final written report signed by the owner within three months of the incident. The	V 366		

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V 366	Continued From page 58 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 reviews, observation and interviews, the facility failed to implement written policies governing their response to level I, II or III incidents. The findings are: Review on 8/5/24 and 8/6/24 of Client #1's record	V 366		

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V 366	Continued From page 59 revealed: -Date of Admission: 6/13/24. -Diagnoses: Moderate Intellectual Developmental Disability; Attention Deficit Hyperactivity Disorder; Anxiety Disorder; Traumatic Brain Injury; Seizure Disorder; Depression. Review on 8/5/24 of Client #2's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Mild Intellectual Developmental Disabilities; Allergic Rhinitis; Constipation; Obesity; Essential Hypertension; Oppositional Defiant Disorder; Seborrheic Dermatitis; Gastro-esophageal Reflux Disease; Major Depressive Disorder; Generalized Anxiety Disorder; Vitamin D Deficiency Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/27/24 of Client #1's T-Logs dated 6/18/24-8/11/24 revealed: -7/5/24 2nd shift: Physical altercation between Clients #1 and #3 resulting in scratches on Client #1's face and arms. -7/21/24 3rd shift: Required multiple redirections to follow rules, tripped and fell causing an injury to both knees. -7/26/24 1st shift, physical altercation between Client #1 and unidentified peer resulting in unidentified peer hitting Client #1 and Client #1 pushing unidentified peer back onto a table. -7/26/24 2nd shift: Claimed she was engaging in sexual intercourse with an unidentified male who	V 366		

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V 366	Continued From page 60 was entering the facility through her bedroom window at night. -7/27/24 7pm-10:00 pm and 11:00 pm: Refused to go to her room or to bed. Stood the carport and back porch of the facility looking for her unidentified male friend. Client #1 had to be reminded that she couldn't have company and required numerous prompts to come back inside. Review on 8/27/24 of Client #3's T-Logs dated 6/1/24-8/11/24 revealed: -6/5/24 at 11:07 am: Broke into the refrigerator, used profanity with staff, called staff racial slurs and attempted to elope from the facility. -6/5/24 at 10:24 pm: Used profanity towards staff, attempted to assault Staff #7, yelled, cussed and slammed doors throughout the facility, "popped other staff (unidentified) in her mouth and busted her (unidentified staff's) lip and continued trying to hit her." -6/11/24 at 8:21 pm: After recently getting caught smoking in her room, was found to have an empty pack of cigarettes, a lighter, and two ash-covered soda cans on her dresser. -7/2/24 at 9:27 pm: Threw a chair at Staff #7, fell while attempting to hit Staff #7, eloped from the facility, threw an object at a cashier in a store, alleged to be physically abused by staff. -7/5/24 at 6:36 pm: Assaulted Staff #7 and struck Client #1 in the face which resulted in Client #1 and Client #3 slapping, punching and scratching each other several times. -7/9/24 at 6:29 am: " ...made a mess in the bathroom and stopped up the toilet ...flushed the toilet making it overflow ...became angry and cussed staff." -7/10/24 at 10:17 pm: Client #3 yelled at and called Client #2 names, slung her plate and cup at an unidentified client. -7/26/24 at 8:51 am: Vaped in the facility	V 366		

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V 366	Continued From page 61 bathroom with Client #1, left urine and feces on the bathroom floor, used inappropriate language and slurs with staff, eloped from the facility, and appeared to have a medical condition requiring staff to notify nursing. -7/31/24 at 8:12 pm: Alleged she was physically abused by a peer and a staff member. Review on 8/7/24 of facility records for 6/1/24-8/7/24 revealed: - No evidence of person(s) being assigned for implementation of corrections and preventive measures, or documentation to determine the cause of incidents involving Client #1 on 7/5/24, 7/21/24, 7/22/24, 7/26/24 and 7/27/24 or Client #3 on 6/5/24, 6/11/24, 7/5/24, 7/9/24, 7/10/24, and 7/26/24. -No evidence of convening a meeting of an internal review team within 24 hours of level III incidents involving Client #3 on 7/2/24, or 7/31/24 to determine the facts and causes of the incidents and to make recommendations for minimizing the occurrence of future incidents. -No evidence that written preliminary findings of fact were sent to the Local Management Entity/Managed Care Organization (LME/MCO) within 5 days of the level III incidents on 7/2/24 and 7/31/24. Interview on 8/7/24 and 9/20/24 with the legal guardian for Client #1 and Client #3 revealed: -"There's been a lot going on ...There's just been so many behaviors in this home (facility) ...there was an incident where [Client #3] was hitting [Staff #7] while [Staff #7] was driving the van. After she hit [Staff #7], she turned around and hit [Client #1] and [Client #1] punched her back and that's the reason they (staff) said she had the other black eye, but I couldn't tell you a date ... I was given behavior data from June 5th-26th	V 366		

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V 366	Continued From page 62 (2024), and it was a book full there was so much. That doesn't even cover anything that happened in July (2024). It was called T-logs. They (staff) do online documentation, but they have issues with staff not entering it all and ...They call it T-logs or behavior data ...they (Licensee) are supposed to have 24/7 awake staff because she (Client #3) has behaviors on all shifts ...on June 7th (2024) she (Client #3) left out the front door and ...called 911 ...honestly [Client #3's] behavior has been a lot for some time ... I had been in the home (facility) to see [Client #3's] prior behaviors and had reports of [Client #3] throwing food or plates ...there was an incident where staff caught [Client #3] and [Client #1] using a vape. It should be in the T-logs and on that same date ...[Client #3] went to a neighbor's house and actually tried to enter and get into the neighbor's house and I don't know what would have happened had she got in ...I was notified on July 26th (2024) on a Friday, that ...[Client #1] told the staff that she was sneaking her boyfriend in the window at night. [QP #1] said some guy was hanging around (the facility) and the neighbors were outside but there is a lot of foot traffic in that area that they are trying to monitor very closely ...I was notified that on July 21st (2024) [Client #1] was trying to go into the shed outside with a housemate, and staff redirected her. How did she get as far as the shed without staff seeing them?" -" ...[QP #1] reported [Client #3's] ...sister was concerned about things going on in the home (facility) ...I have been [Client #3's] guardian for years and it was not like the sister to ever complain ..." Interview on 8/7/24 with the LME/MCO Care Coordinator revealed: -"I have 2 members that live in that home (facility), [Client #3] and [Client #2] ...[Client #3]	V 366		

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V 366	Continued From page 63 has had some pretty significant behaviors ...There seems to be something (incidents) going on all the time with [Client #3] at the group home ...when I was on the phone with [Client #2's] parents (guardians), they ...gave me some insight about the dysfunction of the home (facility) ...There have been incidents in the vehicle. I suggested that RHA (Licensee) request a higher rate for more staff, and they informed me they can't do that because their staff do not document adequately in the system to have evidence of behaviors and it's a poorly managed situation ..." Interview on 8/8/24 and 9/20/24 with Client #2's parent/guardian revealed: -"Recently there's been issues with another client (Client #3) being violent ...My concern is she (Client #3) will push [Client #2] into having behaviors ...My worry is that she will be physically aggressive toward [Client #2]. He is much bigger than her and I don't think she could hurt him, but [Client #2] has a history of being violent towards females and I worry it would set him back to doing things that happened years ago. I'm hoping to get a follow up from [QP #1] at the next meeting. The other client (Client #3) has slapped a 3rd client (Client #1) and there was physical violence in the van ...It's a concern that it's not safe for anyone in the van if there is just 1 staff. The meeting all of this was discussed at was held last month (July 2024) ...I do have the concern that he (Client #2) will be pushed into violence, and this will set him back greatly and there's a risk that he might hurt the female client if she pushes him too far ...I know staff were having problems with her aggression ...[Client #2] went through years of therapy to fix his violent tendencies ...He doesn't care a lot for females anyways, and if he's pushed too far, he could resort to violence again and this would set him	V 366		

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V 366	Continued From page 64 back years ... My concern was a client acting up while staff were driving ..." Interview on 8/12/24 and 8/13/24 with QP #1 revealed: -Reviewed T-Logs for "anything that says they're (clients) not sleeping and stuff like that." -Responsible for the completion and submission of incident reports. -Provided in-service training to staff "on when to report an incident." -She could not locate some incident reports, "I feel like I got stuff. I have documents and I'm trying to get it all organized ...I'm cleaning stuff off my desk ..." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 366	V367 (Cross referenced V109) The Regional Vice President in-serviced all Qualified Professionals and Administrator on RHA reporting requirements for abuse, neglect, and exploitation investigations. This included 24-hour reporting Health Care Registry, IRIS submission, Department of Social Services and guardian notifications. The Regional Vice President/Quality Assurance Specialist will monitor all investigations to ensure reporting requirements are followed ongoing. Completed 9/18/24	
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,	V 367		

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V 367	Continued From page 65 in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of	V 367		

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V 367	Continued From page 66 client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all Level II and III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services are provided within the mandated time frame. The findings are:	V 367		

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V 367	Continued From page 67 Review on 8/5/24 and 8/6/24 of Client #1's record revealed: -Date of Admission: 6/13/24. -Diagnoses: Moderate Intellectual Developmental Disability; Attention Deficit Hyperactivity Disorder; Anxiety Disorder; Traumatic Brain Injury; Seizure Disorder; Depression. Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/27/24 of Client #1's T-Logs dated 6/18/24-8/11/24 revealed: -7/5/24 2nd shift, physical altercation between Clients #1 and #3 resulting in scratches on Client #1's face and arms. -7/26/24 1st shift, physical altercation between Client #1 and unidentified peer resulting in unidentified peer hitting Client #1 and Client #1 pushing unidentified peer back onto a table. Review on 8/27/24 of Client #3's T-Logs dated 6/1/24-8/11/24 revealed: -6/5/24 at 10:24 pm: Used profanity towards staff, attempted to assault Staff #7, yelled, cussed and slammed doors throughout the facility, "popped other staff (unidentified) in her mouth and busted her (unidentified staff's) lip and continued trying to hit her." -7/2/24 at 9:27 pm: Threw a chair at Staff #7, fell while attempting to hit Staff #7, eloped from the facility, threw an object at a cashier in a store, alleged being physically abused by staff.	V 367		

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V 367	Continued From page 68 -7/5/24 at 6:36 pm: Assaulted Staff #7 and struck Client #1 in the face which resulted in Client #1 and Client #3 slapping, punching and scratching each other several times. -7/26/24 at 8:51 am: Vaped in the facility bathroom with Client #1, left urine and feces on the bathroom floor, used inappropriate language and slurs with staff, eloped from the facility, and appeared to have a medical condition requiring staff to notify nursing. -7/31/24 at 8:12 pm: Alleged she was physically abused by a peer and a staff member. Review on 8/5/24 of the facility's internal incident reports for 6/1/24 through 8/5/24 revealed: -7/2/24 at 4:40 pm: Client #3 threw a chair at staff, attempted to hit staff. When staff blocked the hit Client #3 fell causing an injury to her left eye. No description of the injury. No documentation of Client #3 alleging she had been physically abused by Staff #7. -7/22/24 at 8:30 am: Client #1 was physically assaulted on the shoulder and in the face by a male peer (unidentified) causing several red areas to her right forehead, right shoulder, right chest and right bicep. Review on 8/14/24 of additional internal incident reports received from the Intellectual Developmental Disability (IDD) Administrator via email on 8/14/24 at 11:58 am revealed: -A report for Client #1 dated 7/5/24 at 4:30 pm: Client #1 and Client #3 had a physical altercation on the van causing Client #1 to have redness to her upper facial area. -A report for Client #3 dated 7/5/24 at 4:30 pm: Client #3 hit staff from behind, then Client #3 hit Client #1. Documentation that "[Client #3] has old bruising from prior fall. No new areas noted." -No documentation of Client #3 sustaining a	V 367		

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V 367	Continued From page 69 second black eye during the 7/5/24 incident. Review on 8/7/24 of the North Carolina Incident Response Improvement System (IRIS) for 6/1/24-8/7/24 revealed: -No incident reports were submitted for Client #1 on 7/5/24, 7/22/24, or 7/26/24. -No incident reports were submitted for Client #3 on 6/5/24, 7/2/24, 7/5/24, 7/26/24, or 7/31/24. -A report dated 8/4/24 for Client #1 and a report dated 8/4/24 for Client #3 indicated both clients eloped from the facility. No documentation that Client #1 and Client #3 were transported back to the facility inside a vehicle of an unknown male. Interview on 8/19/24 with Staff #2 revealed: -" ...On Sunday August 4th (2024) ...[Client #3] and [Client #1] were watching a movie and at 10:15pm my car alarm went off, and then [Client #3] was outside messing with the car saying they (Client #1 and Client #3) wanted to go to the store, and they wanted to take my car and I ...went to the bathroom and they (Client #1 and Client #3) were gone ...Some guy (unidentified male) pulled up with [Client #3] and [Client #1] later on in a plain car and he did not identify himself ...he (unidentified male) wanted to know if this was an RHA home .... He (unidentified male) pinched [Client #3's] arm and said, 'look how dehydrated she is, how come you guys aren't giving them (clients) enough to drink' and I had to tell him (unidentified male) to stop handling the women (Client #1 and Client #3) and told him to not pinch and touch (clients) and question me to death because I don't even know who he was." -He met with Qualified Professional (QP) #1 about the incident, " I was suspended for 1 day ...and I started working after that 1-day suspension and I have been working 36-40 hours a week."	V 367		

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V 367	Continued From page 70 Interview on 8/7/24 and 9/20/24 with the guardian for Client #1 and Client #3 revealed: -"There's been a lot going on ...There's just been so many behaviors in this home (facility) ...there was an incident where [Client #3] was hitting [Staff #7] while [Staff #7] was driving the van. After she hit [Staff #7], she turned around and hit [Client #1] and [Client #1] punched her back and that's the reason they (staff) said she had the other black eye, but I couldn't tell you a date ... I was given behavior data from June 5th-26th (2024), and it was a book full there was so much. That doesn't even cover anything that happened in July (2024). It was called T-logs. They (staff) do online documentation, but they have issues with staff not entering it all and ...They call it T-logs or behavior data ...they (Licensee) are supposed to have 24/7 awake staff because she (Client #3) has behaviors on all shifts ...on June 7th (2024) she (Client #3) left out the front door and ...called 911 ...honestly [Client #3's] behavior has been a lot for some time ... I had been in the home (facility) to see [Client #3's] prior behaviors and had reports of [Client #3] throwing food or plates ...there was an incident where staff caught [Client #3] and [Client #1] using a vape. It should be in the T-logs and on that same date ...[Client #3] went to a neighbor's house and actually tried to enter and get into the neighbor's house and I don't know what would have happened had she got in ...I was notified on July 26th (2024) on a Friday, that ...Client #1] told the staff that she was sneaking her boyfriend in the window at night. [QP #1] said some guy was hanging around (the facility) and the neighbors were outside but there is a lot of foot traffic in that area that they are trying to monitor very closely ...I was notified that on July 21st (2024) [Client #1] was trying to go into the shed outside with a housemate, and staff	V 367		

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V 367	Continued From page 71 redirected her. How did she get as far as the shed without staff seeing them?" -On 8/4/24 Client #1 and Client #3 eloped from the facility. Client #3 "asked someone in a car to give her a ride ..."that must have been a long event for them (Client #1 and Client #3) to go to a store and ask for a ride ..." Interview on 8/15/24 with Client #3's sister revealed: -" ... I don't feel like she (Client #3) is in good hands there (facility) ...There is controversy over and over and over ...the last 6 months has been worse than it's ever been ...Really since November of last year (2023), things have just got worse and worse ..." Interview on 8/7/24 with the LME/MCO Care Coordinator revealed: -"I have 2 members that live in that home (facility), [Client #3] and [Client #2] ...[Client #3] has had some pretty significant behaviors ...There seems to be something (incidents) going on all the time with [Client #3] at the group home ... when I was on the phone with [Client #2's] parents (guardians), they ...gave me some insight about the dysfunction of the home (facility) ...There have been incidents in the vehicle. I suggested that RHA (Licensee) request a higher rate for more staff, and they informed me they can't do that because their staff do not document adequately in the system to have evidence of behaviors and it's a poorly managed situation ..." Interview on 8/8/24 and 9/20/24 with Client #2's parent/guardian revealed: -"Recently there's been issues with another client (Client #3) being violent ...My concern is she (Client #3) will push [Client #2] into having behaviors ...My worry is that she will be physically	V 367		

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V 367	Continued From page 72 aggressive toward [Client #2]. He is much bigger than her and I don't think she could hurt him, but [Client #2] has a history of being violent towards females and I worry it would set him back to doing things that happened years ago. I'm hoping to get a follow up from [QP #1] at the next meeting. The other client (Client #3) has slapped a 3rd client (Client #1) and there was physical violence in the van ...It's a concern that it's not safe for anyone in the van if there is just 1 staff. The meeting all of this was discussed at was held last month (July 2024) ...I do have the concern that he (Client #2) will be pushed into violence, and this will set him back greatly and there's a risk that he might hurt the female client if she pushes him too far ...I know staff were having problems with her aggression ...[Client #2] went through years of therapy to fix his violent tendencies ...He doesn't care a lot for females anyways, and if he's pushed too far, he could resort to violence again and this would set him back years ... My concern was a client acting up while staff were driving ..." Interview on 8/12/24 and 8/13/24 with QP #1revealed: -Reviewed T-Logs for "anything that says they're (clients) not sleeping and stuff like that." -Responsible for the completion and submission of incident reports. -Provided in-service training to staff "on when to report an incident." -She could not locate some incident reports, "I feel like I got stuff. I have documents and I'm trying to get it all organized ...I'm cleaning stuff off my desk ..." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals	V 367		

Division of Health Service Regulation

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V 367	Continued From page 73 (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions;	V 500	V500 (Cross referenced V109) The Regional Vice President in-serviced all Qualified Professionals and Administrator on RHA reporting requirements for abuse, neglect, and exploitation investigations. This included 24-hour reporting Health Care Registry, IRIS submission, Department of Social Services and guardian notifications. The Regional Vice President/Quality Assurance Specialist will monitor all investigations to ensure reporting requirements are followed ongoing. Completed 9/18/24	

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V 500	Continued From page 74 (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all instances of alleged abuse were reported to the local Department of Social Services (DSS). The findings are: Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism;	V 500		

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V 500	Continued From page 75 Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/27/24 of Client #3's T-Logs dated 6/1/24-8/11/24 revealed: -7/2/24 at 9:27 pm, entered By Staff #7: -Client #3 attempted to strike Staff #7. -Staff #7 blocked Client #3 from striking her. -Client #3 fell and "landed right on top of her eye" resulting in bruising and swelling. -Client #3 spoke on the phone with QP #1 and alleged she had been physically abused by Staff #7. -7/31/24 at 8:12 pm, entered By Staff #6: -Client #3 reported to her Uncle that "staff hits her." -Client #3 then reported the same information that "staff hits her" to her Sister. Review on 8/5/24 of the facility's internal incident report dated 7/2/24 and signed by QP #1 on 7/5/24 revealed: -On 7/2/24 at 4:40 pm: -Client #3 attempted to hit staff #7, Staff #7 blocked the hit. -Client #3 turned around and fell face-first on the floor without bracing for the fall. -Documented injury to Client #3's left eye. -No documentation that Client #3 alleged she was abused by Staff #7. -No documentation of notification to the Department of Social Services (DSS). Review on 8/7/24 of the North Carolina Incident Response Improvement System (IRIS) for 6/1/24-8/7/24 revealed: -No evidence that the allegation of abuse against Staff #7 was reported to DSS.	V 500		

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V 500	Continued From page 76 Interview on 9/11/24 with Client #3 revealed: -" ...[Staff #7] got mad at me, and I don't know why. She came over to me towards the refrigerator and she threw me on the floor near the refrigerator and my eye was swollen shut and I couldn't see at all. [Staff #7] started it. I didn't do nothing. But they keep hitting me and abusing me and I'm not going back ..." Interview on 8/15/24 with Staff #7 revealed: -Was working on 7/2/24 when Client #3 sustained a black eye, " ...I want to say that one was her left eye ...She said I choked her and all kinds of stuff ..." -Was aware allegations were made against her "as soon as it happened ...that I was stealing her (Client #3's) belongings, and that I choked her and that I hit her ...I spoke with [Qualified Professional (QP) #1] and DSS came around, but they never spoke to me ..." Interview on 8/13/24 with QP #1 revealed: -Client #3 received a black eye on 7/2/24 "during the behavioral incident that took place. I was actually on the phone with her afterward. It would have been when [Staff #7] was working ...She threw a chair and went to hit [Staff #7] and [Staff #7] put her arm up to block and [Client #3] turned around and she fell ...after the incident she spoke to me on the phone. She (Client #3) initially told me staff had hit her. She said it was [Staff #7]. I talked to her for a little bit longer and was trying to get her to calm down and before I got off the phone with her, she said she fell and that she hadn't told the truth about it and that she went to hit [Staff #7] and got tripped up and she had fell ...I was on the phone with [Client #3] for close to an hour ..." -The protocol for reporting allegations was, "It needs to be reported immediately if there is	V 500		

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V 500	Continued From page 77 suspicion of abuse, or neglect and suspend the staff until what happened can be determined ...Like with [Client #3], she is verbal and able to tell what happened with everything ..." -Identified suspicion as, "Any bruising, anything like that or verbal. But [Client #3] has made false allegations, and I asked her multiple times, and she wasn't around staff when I was talking to her, so she wasn't being influenced." -Client #3's allegation was not reported "because I had talked to [Client #3] and when she first said [Staff #7] hit her and when I continued to talk to her, she said she got turned around and got tripped up and she does have a history of false reporting and I asked her multiple times before I got off the phone with her, what happened." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 500		
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	V 513	V513 Quality Assurance or Operational Leadership will provide in-service training to Qualified Professionals on RHA's rights restrictions and documentation process. Clinical team will monitor rights restriction documentation thru monthly chart reviews. By 1/19/25	

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V 513	Continued From page 78 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 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 reviews, and interviews, the facility failed to provide services which promoted a safe and respectful environment using the least restrictive and most appropriate settings and methods. The findings are: Review on 8/5/24 of Client #1's record revealed: -Date of Admission: 6/13/24. -Diagnoses: Moderate Intellectual Developmental Disability; Attention Deficit Hyperactivity Disorder; Anxiety Disorder; Traumatic Brain Injury; Seizure Disorder; Depression. -No documentation of Client #1 stealing food and beverages. Review on 8/6/24 of Client #1's Treatment Plan dated 5/23/24 revealed: -No goals/strategies for theft of food and beverages. Review on 8/5/24 of Client #2's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Mild Intellectual Developmental Disabilities; Allergic Rhinitis; Constipation;	V 513		

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V 513	Continued From page 79 Obesity; Essential Hypertension; Oppositional Defiant Disorder; Seborrheic Dermatitis; Gastro-esophageal Reflux Disease; Major Depressive Disorder; Generalized Anxiety Disorder; Vitamin D Deficiency. -No documentation of Client #2 stealing food and beverages. Review on 8/6/24 of Client #2's treatment plan dated 1/11/24 revealed: -No goals/strategies for theft of food and beverages. Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/6/24 of Client #3's treatment plan dated 7/31/24 revealed: -No goals/strategies for theft of food and beverages. Review on 8/6/24 of Client #3's unsigned behavioral support plan (BSP) dated 1/20/24 revealed: -"Due to maladaptive behaviors and medical concerns, [Client #3] has restrictions written into her plan of ...fluid restrictions and locked food and storage areas. These restrictions will be reviewed by the Human Rights Committee and regularly reviewed for necessity at plan renewal ..." -"[Client #3] earns access to cigarettes every two hours from 8am until 8pm when respecting others' boundaries and privacy ...[Client #3] has	V 513		

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V 513	Continued From page 80 access to one [soda] per day. These are kept at RHA (Licensee Office), not at the house (facility), as she will sneak and steal them ...Refrigerator and food storage areas are locked so she will not gorge herself ..." -"Access to cigarette can be delayed for a period of time ...if behaviors are severe (...repetitive requests/demands for food or drink; excessive use of bathroom during the night ...)" -"[Client #3] will obsess around her ...access to sodas and food, where she wants to eat and what she wants to eat ...[Client #3] is on heart-healthy diet and has a 2 liter fluid restriction, with limited fluids after 4pm ...[Client #3] is known to obsess about using the bathroom. She will get up multiple times during the night to use the bathroom. If she gets up more than two times, her first cigarette will be delayed. [Client #3] has had several instances of urinating in her bedroom - in the throw rug and other places ...She has a history of going AWOL (Absence Without Leave) to purchase cigarettes and sodas and so her money is not kept at the home (facility) but is kept at the vocational center (day program) ..." -The fields for dates and signatures of the Clinician/Licensee, Guardian, Qualified Professional, and the Local Management Entity/Managed Care Organization (LME/MCO) Care Manager, were all left blank. Review on 8/13/24 of Human Rights Committee (HRC) Documents revealed: -None of the documents contained signatures of HRC members. -None of the documents provided any details of client behaviors to justify the ongoing need for rights restrictions at Sparta Road Home. Interview on 9/10/24 with Client #1 revealed: -"I am on a smoking schedule."	V 513		

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V 513	Continued From page 81 -"If I want to make a phone call, I have to ask staff, and the staff call [Qualified Professional (QP) #1] and ask if it's okay." -If QP #1 was not available on weekends, she would have to wait until Monday to make a phone call. Interview on 9/10/24 with Client #2 revealed: - "We (clients) just eat at mealtime, if it's breakfast, lunch, or dinner. We don't get any snacks in between. I guess they (staff) are trying to get us (clients) to lose weight ...there are a couple of staff that works at other houses (sister facilities) that come in and give us (clients) a snack at 3:00 (pm) because they are used to giving their own people (sister facility clients) snacks." -Staff took clients out to eat, "Only certain people (clients) are allowed to eat if they (clients) behave. If they (clients) have certain behaviors, they don't get to eat out. They (clients) watch everyone eat and when they get home, they fix them a sandwich or something like that. It happened to me a long time ago ...It just happened to [Client #3] recently ...[Client #3] asked for a milkshake, and she didn't get one because she wasn't allowed to eat that day except at home." -"Staff told [Client #3] to go back to bed and that she couldn't use the bathroom and that's why she (Client #3) peed in her room and stuff when certain staff worked." -"We have to ask to use the phone. We can't just get the phone and call somebody without getting staff permission. It's kept in the pantry locked up ...it stays locked up all the time." Interview on 9/11/24 with Client #3 at a respite care facility revealed: -" I couldn't have water or milk or nothing, and	V 513		

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V 513	Continued From page 82 they (staff) kept food away from me ...I wasn't eating nothing. All I wanted to do was eat or drink and they (staff) wouldn't fix me nothing. All of them wouldn't feed me. I like meatballs, ravioli, chicken pot pie and they wouldn't fix me nothin'. If they cooked, they said 'if you don't like it, don't eat it, but I'm not fixing something else.'" -She was not allowed to call her sister, "or anybody on the phone at Sparta Road (facility). They (staff) wouldn't let me. They keep the phone locked up and won't let us (clients) use it ...[Direct Support Supervisor] said we can only call our guardians and that we need to do that when we are at work (vocational center)." -Her privileges of going out to dinner, smoking cigarettes and drinking sodas were taken away. "I had been good, and they (staff) took it away from me. They took me out in the van and ate in front of me and said I can't have the take-out (food) unless I had good behavior. All the staff do this. All of them took it away. You have to earn your stuff (rights) and they (staff) can take that right from you and say you can't eat out. They eat and drank in front of me. I wasn't allowed to eat. I wanted a milkshake, and they wouldn't get me that either ...I earned my milkshake ...I had my own money to buy mine ...They (staff) wouldn't fix nonthin' to eat if they eat out and I couldn't even have a shake." -"Staff have a key, and they give [Client #1] and [Client #2] the key to get all the food and drink they want but if I want something they won't let me. There's a freezer and refrigerator and they have a lock on both sides. You need a key to open the refrigerator, and the rest of the food and drinks is locked on a key, too. I'm not allowed a snack ...I've lost a lot of weight. I'm eating better here (respite care facility)." -At night, "If I got up more than 1 time, they (staff) took my cigarette. I couldn't hold my urine or the	V 513		

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V 513	Continued From page 83 other (stool). If I went to the bathroom I couldn't have the cigarette. I would use the bathroom on myself in the bedroom because if you have to go, you have to go. I had accidents in my room peeing ...or I would lose my cigarette." Interview on 8/15/24 with Staff #1 revealed: -Client #3 was allowed 1 cigarette every 3 hours and her fluids were restricted "because she is prone to having accidents." -The refrigerator and food pantry in the facility were both kept locked to prevent clients from "food snatching and overeating." -If a client requested food and/or beverages outside of the scheduled routine time, "I give them drinks, but food we (staff) aren't supposed to give ..." Interview on 8/19/24 with Staff #2 revealed: -He had "no idea [Client #3] had any restrictions." -All of the food in the facility was locked up. "Some people (clients) steal it if it isn't locked, or they get up in the middle of the night to steal it." -The facility had 2 phones. 1 was locked up in the food pantry and the other was on the Direct Support Supervisor's desk. -"Clients are not allowed to answer the phone. They (clients) can make calls, but there are certain stipulations on who can make calls and there is a list there with their (clients) names and if they are allowed to make calls and on what days and what times and who they are allowed to call." Interview on 8/16/24 with Staff #3 revealed: -All of the food was locked up at the facility. -"I know they (staff) keep things locked up because of the food stealing." Interview on 8/19/24 with Staff #4 revealed:	V 513		

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V 513	Continued From page 84 -All of the food in the facility was locked up. -The clients have "no access to food." -Clients were "eligible for free snacks unless something in their plan says otherwise." -Staff were permitted to give 1 free food to clients per shift outside of the scheduled mealtime. Interview on 8/15/24 with Staff #5 revealed: -Client #3 had some rights restricted, "She has liquid restrictions, and she has a cigarette time assigned." -Both the food pantry and refrigerator were locked at Sparta Road Home. -If clients wanted food or beverages, "if it's not within a set time, they get redirected." Interview on 8/16/24 with Staff #6 revealed: -"The only restriction I know (for Client #3) is fluids, that's the only one I know of ..." -At the facility, "the freezer and refrigerator is locked up as well as the pantry. I know they (staff) said at one point that [Client #2] used to steal food or something ..." -The facility phone was kept in the pantry and the pantry was locked. Interview on 8/15/24 with Staff #7 revealed: -The facility had "locked cabinets, pantries, stuff like that. A couple of them (clients) like to food snatch ...They have scheduled 3 meals a day and snacks twice a day. If they (clients) want extra, they need to ask because they (Licensee) don't want them (clients) in the refrigerator or pantry by themselves ..." -The facility freezer, refrigerator and food pantry was kept locked. -She allowed clients to have food when it was outside of the time for snack, "but I have heard from every client's mouth in that home (facility) that nobody else does that ...some (staff) don't	V 513		

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V 513	Continued From page 85 allow a 3pm or 7pm snack ..." -There's only 1 phone at the facility and "it's kept locked in the pantry. If they (clients) want to make a phone call, they have to ask. I don't think they are on any phone restrictions." Interview on 8/21/24 with the Direct Support Supervisor revealed: -"The only restriction I know she (Client #3) has is a fluid restriction, but as far as any behavior support plan, I don't think she has a restriction." -The food pantry and refrigerator were locked at the facility, "Basically, they are locked so clients don't food snatch because it was becoming a habit and if [Client #3] has a [soda] in there, she is bad for sneaking in there and drinking them all at once, loke within an hour ..." -Clients were permitted to have a snack at 3pm and 8pm. -The facility phone was kept in the pantry, "Staff get the phone whenever they (clients) ask" to make a call. Interview on 8/12/24 with Qualified Professional (QP) #1 revealed: -Food and beverages were securely stored in a locked area at the facility to prevent clients from "snatching food." -Client #1 was "getting up at night and snatching food" at her previous placement. -Client #1 was supposed to be following an 1800 calorie diet. - "[Client #2] is diabetic and snatches food. Locks were initially put in place because of him ...it is a dangerous thing if he (Client #2) eats too much sugar, there is a safety concern. He would food snatch." -Client #3 was on fluid restrictions. -Client Rights Committee met quarterly to review consents that were signed off on. "It's (client	V 513		

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V 513	Continued From page 86 right's restrictions) talked about and there's minutes ..."	V 513		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the	V 536	V536 All staff were in-serviced on ProAct part A Verbal De-escalation by a certified ProAct Instructor. Clinical team completed Interaction Assessments 3x per week for 4 weeks and will be completed ongoing monthly. Administrator will review new hire training records to ensure ProAct training is completed before working in the home. Completed 9/18/24	

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V 536	Continued From page 87 following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program	V 536		

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V 536	Continued From page 88 aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the	V 536		

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V 536	Continued From page 89 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 4 audited paraprofessionals (Staff #7) failed to implement practices that emphasized the use of alternatives to restrictive interventions. The findings are: Review on 8/20/24 and 11/20/24 of Staff #7's record revealed: -Date of Hire: 7/6/23. -Job Title: Direct Support Professional. -Professional Assault Crisis Training (Pro-ACT) certification dated 6/14/24-6/14/25. -Pro-ACT refresher certification dated 9/25/24-9/25/25.	V 536		

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V 536	Continued From page 90 Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. -Physician's order for hydroxyzine pamoate 50 milligram (mg) capsule, 1 by mouth (PO) as needed for anxiety, up to 4 doses in 24 hours. Review on 8/27/24 of Client #3's T-Logs dated 6/1/24-8/11/24 revealed: -7/2/24 at 9:27 pm, "Entered By [Staff #7] ... [Client #3] was finishing up shower at beginning of my shift. She wanted to speak to her guardian and immediately began hoarsely screaming at her guardian about a vape and how she wanted a new home and guardian. She (Client #3) also told her (Client #3's guardian) she would run away sometime tomorrow to get her a vape. She redirected her anger to staff about the menu for supper. I told her demanding me is not acceptable and she would have her special order tomato sandwich & the same sides as housemates. She didn't agree and picked up her chair & threw it at me 5 ft (feet) apart from each other. I told her she needed to go to her room and followed behind her. She reared back to strike and walk away but her hit was blocked causing her to fall into her turnaround. She landed right on top of her eye and it caused bruising and swelling. She then gets up and walks out front door, goes to the store to beg for cigarettes & [soda]. As I walked into the store I heard the cashier explaining they don't have money to buy [sodas] and as [Client #3] seen me she picked up a lighter & threw it at the cashier. I told her we needed to leave because cashier could report an	V 536		

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V 536	Continued From page 91 assault and bring more trouble ..." -7/5/24 at 6:36 pm, "Entered by [Staff #7] ...[Client #3] was obsessing about a prn (as needed medication) for anxiety around 3:30 (pm) ...I told her she has to be showing signs of anxiety (she had none). She then requested a milkshake despite losing dinner outing this evening and I told her I would not do it, she could have diet soda at home. On the way to dinner outing ...she became combative accusing housemates and myself of laughing at her. She hit me from behind then turned to [Client #1] to her right and struck her face. They (Client #3 and Client #1) slapped, punched, scratched each other several times. I was able to pull over within 20 seconds and deescalate the 2. She had a PRN for anxiety and cigarette when she got home." -No documentation of Staff #7 utilizing intervention strategies for defusing and de-escalating potentially dangerous behaviors during the 7/2/24 incident. Review on 8/5/24 of the facility's internal incident reports for 6/1/24-8/5/24 revealed: -On 7/2/24 at 4:40 pm "Location of Incident ...hallway between refrigerator and living room ... [Client #3] was verbally aggressive ...started yelling at staff (Staff #7) ...She (Client #3) picked up a chair & threw it at staff & then attempted to hit staff. When staff blocked the hit [Client #3] turned around and fell. She (Client #3) didn't brace her (herself) for the fall and landed face first on the floor ..." -Indicate location of injury: An X was marked across the left eye of the illustration of a body outline on the incident report. Type of Injury with options to check boxes for redness, swelling, bruise, scratch, abrasion, etc. had not been filled out. Description of the injury and treatment given: No details were documented to describe the	V 536		

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V 536	Continued From page 92 injury. Review on 8/14/24 of an additional internal incident report received from the IDD Administrator via email on 8/14/24 at 11:58 am revealed: -On 7/5/24 at 4:30 pm "Description of the incident: ...While in the van [Client #3] felt like she was being picked on by housemates. She hit staff (Staff #7) from behind while using foul language, then [Client #3] hit [Client #1] ...[Client #3] got angry @ (at) [Client #1] on van for feeling bullied and struck [Client #1] in face. [Client #3] has old bruising from prior fall. No new areas noted ..." -Indicate location of injury: An X was marked across the left eye of the illustration of a body outline on the incident report, with "Old bruising from prior fall" handwritten beside it. Type of Injury with options to check boxes for redness, swelling, bruise, scratch, abrasion, etc. had a check beside box #15 Other: "Nothing new observed at this time" was handwritten beside it. Description of injury and treatment given: No documentation to indicate Client #3 had been physically struck by anyone during the altercation. Review on 8/15/24 and 8/19/24 of an undated photo of Client #3 received by Client #3's sister on 8/14/24 revealed: -Client #3's left eye was closed and swollen. The swelling extended past the bridge of Client #3's nose and was in the shape of an egg. There was bruising of a dark purple color across the entire eyelid, eye socket and surrounding skin below the eye. Review on 8/14/24 of Provider Notes for Client #3 from a Radiology Department at a local Medical Center dated 7/8/24 revealed:	V 536		

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V 536	Continued From page 93 -"Diagnoses: Blunt trauma of face, initial encounter ...X-Ray Sinuses ...Indication: Unspecified injury of face ..." Review on 8/14/24 of Provider Notes for Client #3 from an Emergency Department (ED) at a local Medical Center dated 7/9/24 revealed: -"Patient (Client #3) presents to ED from a group home ...according to the staff member at bedside ...There was a fall recently ...where the patient sustained facial and head injury ..." -"Left facial hematoma noted ...Subconjunctival hemorrhage noted to the left eye from the 2:00 around to the 8 o'clock position ..." -Computed Tomography (CT) scan of head indicated for "Head trauma, moderate-severe ...No evidence of fracture ...Soft tissue swelling/hematoma over the lateral left frontal bone ..." -CT scan of facial bones indicated for "facial trauma - left periorbital ...Soft tissue swelling seen in the left supraorbital region with small lateral left supraorbital soft tissue swelling/scalp hematoma ..." Review on 9/9/24 of documents enclosed in a folder labeled "Sparta Rd. (Road) August 2024 Investigation" received from the Licensee on 9/9/24 revealed: -An unsigned handwritten document titled Interview with Client #1 on 8/27/24: -"[Client #3] got upset and tried to throw a chair @ [Staff #7] and [Staff #7] pushed [Client #1] from the back causing [Client #3] to trip. [Client #3] fell & hit her head at the edge of fridge ...[Staff #7] told her & [Client #2] not to say anything so she wouldn't get in trouble & that [Client #3] tripped. 'look you tripped over your own two feet you old b***h' ..." -A typed document with the following:	V 536		

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V 536	Continued From page 94 -"Convening Authority: [Intellectual Developmental Disability (IDD) Administrator]" -Investigator: Qualified Professional (QP) #2 and Quality Assurance Specialist -"In the case of: [Client #3]" -"Facts &/or Summary of Evidence: On 08/27/2024, [Client #1] reported to [QP #2] that she had witnessed [Staff #7] push [Client #3] in the back on 07/02/2024 causing her to fall and get a black eye ...During an interview with [Staff #7] she reported [Client #3] was upset with her on the day of 07/02/2024 but couldn't be certain why. She stated that [Client #3] picked up a wooden chair and threw it at her. [Staff #7] stated that she tried to redirect [Client #3] to her bedroom and was walking behind [Client #3] when she turned around and reared back with her left arm. [Staff #7] stated that she blocked [Client #3's] arm with an open right hand and that [Client #3] then spun to her left a full 180 degrees and stumbled and fell, hitting her left eyebrow ...[Staff #7] said she then called [QP #1] for assistance ...[Staff #7] also stated that she sent a picture of [Client #3's] initial bruise to [QP #1]. During the interview with [Staff #7], she demonstrated using [Quality Assurance Specialist], how she blocked the hit from [Client #3]. The block was used appropriately. [Staff #7] completed a T-Log on 07/02/2024 ...The way she described the incident in the T-Log is the same as she described it happening during her interview on 08/28/2024. This investigator reviewed the photo sent to [QP #1] by [Staff #7]. In the photo, [Client #3] appears to have swelling and purple discoloration below her left eyebrow. During an initial interview with [Client #2], he stated that he had witnessed [Staff #7] push [Client #3] , causing her to trip and fall. He also stated that [Staff #7] called [Client #3] a 'cracker' and told her that it 'takes an N word to know an N word' ..."	V 536		

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V 536	Continued From page 95 Interview on 8/15/24 with Client #3's sister revealed: -Client #3 "has complained so much about staff calling her names. She has called them names and used the N word which should not have happened and I'm sure some staff have taken it personal what she has called them, but once you call somebody those names people don't take too kindly to that and people then tend to feed off each other. I don't feel like she is in good hands there (facility). She says they laugh at her and they call her names. They have young staff there, and I don't think they have been properly trained on how to de-escalate things ...There is controversy over and over and over. They aren't trying to help her. [Staff #7] was working and there was some kind of altercation and somebody that works there sent somebody a picture of [Client #3's] eye and that person sent it to me. [Staff #7] tried to block [Client #3] from hitting her (Staff #7) and she (Client #3) turned around and maybe fell. [Client #3] would report she was hit and then that she stumbled ...Staff has changed drastically, and I don't think anyone that used to work there is still there ...there was never any issues like they are having right now. I ...did have a discussion (with QP #1) about the staff ...and she (QP #1) said ...'they will have staff training' ...I replied, the home (facility) needs training. [QP#1] replied 'we are doing more training and monitoring closely' ...She (Client #3) asks for food, but they (staff) tell her 'no' ...She (Client #3) lost her privilege to go out to eat. [Staff #7] took them (clients) out to eat 2-3 months ago and [Client #3] wasn't allowed to order anything other than a soda ...[Client #3] had a fall on July 2nd (2024) and ...her eye was so swollen, and she couldn't see out of it ... [Client #3] was concerned for her safety and well-being there ...[Client #3]	V 536		

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V 536	Continued From page 96 claimed [Staff #7] pushed her." Interview on 8/7/24 with Client #3's guardian from an outside agency revealed: -"I am aware of 2 black eyes, both were in such a short time period of 2 similar incidents ...The pictures that I did see after the fact were taken by a family member and they were God awful. They were in different stages of healing ..." -"When I spoke with [Client #3] on 7/2/24, she was saying she was going to go AWOL (absence without leave) and she did go AWOL and that was the day she got the black eye. I clearly remember the call with [Client #3] on 7/2/24 because her voice was very coarse, and she was yelling and screaming and very upset. I was trying to calm her down and I heard a staff member in the background laughing ..." -"There was also an incident when [Client #3] was hitting [Staff #7] while [Staff #7] was driving the van. After she hit [Staff #7], she turned around and hit [Client #1] and [Client #1] punched her back and that's the reason they said she had the other black eye, but I couldn't tell you a date ..." Interview on 8/7/24 with the Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator revealed: -" ...concerns have been related to ...the staff not being trained on the behavior support plans ...around the July 4th (2024) holiday, and I saw a picture of [Client #3] with black eyes ...When I visited the facility, there were conflicting stories of how the black eyes were obtained. One story was that she (Client #3) hit a female resident and then she was hit back. I was told the second black eye was that she (Client #3) ran and fell, and another was she was trying to hit staff. I just don't know what really happened."	V 536		

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V 536	Continued From page 97 Interview on 9/11/24 with Client #3 revealed: -"It was bad. Not good at all. It was horrible at Sparta Road (facility). It was bad. It got worse. They brought me here ...to get away from the staff that are going downhill so bad and I'm not going back ...because they choked me and threw me on the floor, I couldn't have water or milk or nothing and they kept food away from me. ... Well, [Client #1] won't keep her hands off me and she blacked my eye by keeping hitting it and this eye was beaten black and blue. [Staff #7] and [Client #1] were hitting on me. [Staff #7] got mad at me, and I don't know why. She came over to me towards the refrigerator and she threw me on the floor near the refrigerator and my eye was swollen shut and I couldn't see at all. [Staff #7] started it. I didn't do nothing. But they keep hitting me and abusing me and I'm not going back ... They took me out in the van and ate in front of me and said I can't have the take-out unless I had good behavior ...They eat and drank in front of me. I wasn't allowed to eat. I wanted a milkshake, and they wouldn't get me that either. [Staff #7] was all over me. I told her I earned my milkshake from [local restaurants], and she wouldn't let me get one. I had my own money to buy mine and she (Staff #7) wouldn't let me eat out ...I couldn't even have a shake." Interview on 8/15/24 with Staff #7 revealed: -She was working alone at the facility for both incidents in which Client #3 sustained a black eye. -On 7/2/24 when Client #3 sustained a black eye, " ...I want to say that one was her left eye. She was very upset. Her behaviors have gotten to the point of her doing things like leaving the house to go the store. She lifted a chair and was going to hit me, and I redirected her to her room, and she immediately turned a 180 (degrees) and stumbled	V 536		

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V 536	Continued From page 98 and landed right on her face. She literally was facing me and did a 180 and her back was facing me, and she was walking away and she hit the floor directly on the side of her face ...She did raise her hand and I stopped her by backing away from her, but I moved away from her and she turned and her arm was out and she turned and fell. I did not make contact with her. She said I choked her and all kinds of stuff ..." -On 7/5/24 " ...a week later, she (Client #3) ended up with a second black eye from fighting in a vehicle and there was just so much going on, we were having so many issues ...I know it was on a Friday because we were going on a dinner outing in July (2024). I mean it was the same kind of behaviors. I was taking the other 2 roommates (Client #1 and Client #2) out for their dinner outing and [Client #3] wouldn't have come with us, but there wasn't extra staff, so she came along. [Client #3] wanted a milkshake, and she expected a milkshake, and I said we will do what we normally do and have a soda. [Client #3] hit [Client #1] in the face, and they were throwing punches at each other's face while we were at a stoplight. I was able to pull over and separate them ...She (Client #3) did strike me from behind that day while I was in the driver's seat and the van was in motion ... Whoever gets a dinner outing it's every 2 weeks on a Friday. If it's all of us, we go to a sit-down restaurant and if she (Client #3) misbehaves our managers make the decision if she gets to eat out or not. [Client #3] wouldn't have been eating, but she was allowed to have a soda at home, or when we went to the restaurant. She said, 'Okay I guess I'm never going to get to go out and eat again' and so she gave up efforts of eating out. If all 3 (clients) can't eat, then I go through a drive through and try to make [Client #3] feel better by giving her a soda, but she wanted a milkshake ..."	V 536		

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V 536	Continued From page 99 Interview on 8/13/24 with QP #1 revealed: -Client #3 had black eyes on 2 separate occasions, one on 7/2/24 and one on 7/5/24. -"The first one (black eye) was during the behavioral incident that took place (7/2/24) ...It would have been when [Staff #7] was working. She (Client #3) was upset ...she wasn't satisfied with what they were having for dinner. Alternatives were offered. She threw a chair and went to hit [Staff #7] and [Staff #7] put her arm up to block and [Client #3] turned around and she fell ...after the incident she spoke to me on the phone. She (Client #3) initially told me staff had hit her ..." -Client #3 sustained a second black eye to her other eye when "[Client #3] hit [Client #1] on the van and [Client #1] hit her back." Interview on 11/20/24 with the Senior Vice President of Operations revealed: -All facility staff have received refresher training in ProACT. Review on 9/17/24 of a Plan of Protection completed by the Intellectual Developmental Disability (IDD) Administrator on 9/17/24 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? All staff will be in-serviced on ProAct part A - verbal de-escalation by a certified ProAct instructor by 9/18/2024 at 5pm. Describe your plans to make sure the above happens. The clinical team will complete interaction assessments 3x (times) a week for four weeks then on a routine basis. The administrator will review new hire training records to ensure ProAct training is completed for new hires before working	V 536		

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V 536	Continued From page 100 in the group home on going. All staff will be in-serviced on proact part A - verbal de-escalation by a certified ProAct instructor by 9/18/2024 at 5 pm." Client #3 had diagnoses including Moderate Intellectual Developmental Disability, Schizoaffective Disorder, Obsessive Compulsive Disorder, Eating Disorder, Depression, History of Pulmonary Embolism, Hiatal Hernia, Cataracts, Gastroesophageal Reflux Disease, and Constipation. On 7/2/24 and 7/5/24, Staff #7 was the only staff on duty when Client #3 engaged in behavioral outbursts which included verbal threats, attempted assault, and assault. Staff #7 did not provide intervention strategies during either episode to defuse and de-escalate Client #3's behaviors. On 7/5/24, Staff #7 also denied Client #3's request for her prn dose of hydroxyzine pamoate which was prescribed to assist in minimizing Client #3's behaviors. As a result of the incidents, Client #3 sustained head and facial injuries. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 536		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a	V 542	V542 Administrator will in-service Business Manager and Qualified Professionals of receipt requirements for Client's Personal Funds. Business Manager will monitor all receipts going forward on a monthly basis. By 1/19/25	

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V 542	Continued From page 102 -Diagnoses: Mild Intellectual Developmental Disabilities; Allergic Rhinitis; Constipation; Obesity; Essential Hypertension; Oppositional Defiant Disorder; Seborrheic Dermatitis; Gastro-esophageal Reflux Disease; Major Depressive Disorder; Generalized Anxiety Disorder; Vitamin D Deficiency. Review on 8/5/24 of Client #3's record revealed: -Date of Admission: 12/21/13. -Diagnoses: Moderate Intellectual Developmental Disability; Schizoaffective Disorder; Obsessive Compulsive Disorder; Eating Disorder; Depression; History of Pulmonary Embolism; Hiatal Hernia; Cataracts; Gastroesophageal Reflux Disease; Constipation. Review on 8/20/24 of the Client Funds Management Policy revealed: -" Receipts for purchases must be returned to the business office for account reconciliation within 3 days." -"Any withdrawal from a resident account must match a cash receipt or check that disburses to a resident, family member, facility account or vendor." -"All receipts must match the RFMS (Resident Fund Management Service) withdrawal record and be maintained at the business office." Review on 8/21/24 of Client #2's Credit Card Log revealed: -7/5/24 $22.18 to Staff #6. Purpose of Expenditure: Out to Eat. No receipt. Review on 8/21/24 of Client #3's Credit Card Log revealed: -6/24/24 $296.16 shopping at various stores. No receipts. -7/22/24 $79.24 cigarettes and food at various	V 542		

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V 542	Continued From page 101 personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money; (2) regulate the receipt and distribution of funds in a personal fund account; (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account; (5) assure that a client's personal funds will be kept separate from any operating funds of the facility; (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client; (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and (8) provide the client with a quarterly accounting of his personal fund account. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain records regarding the receipt and distribution of client funds for 2 of 3 clients (Client #2 and Client #3). The findings are: Review on 8/5/24 of Client #2's record revealed: -Date of Admission: 12/21/13.	V 542		

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V 542	Continued From page 103 stores. A receipt for tobacco products totaling $36.90 dated 7/29/24, a receipt for snacks totaling $10.25 dated 7/26/24, and a receipt for tobacco products totaling $32.09 dated 8/15/24. Review on 8/21/24 of Resident Fund Withdrawal Reports and Receipts dated November 2023 - June 2024 revealed: -11/16/23 Client #2 $20.00 Pocket Money, Requested By and Received By were left blank. No Receipt. -12/5/23 Client #3 $10.00, purpose not documented. No receipt. -12/15/23 Client #3 $10.00 Pocket Money and Client #2 $10.00 Pocket Money, Received By: Unaudited Staff Member. No Receipts. -1/12/24 Client #2 $10.00 Pocket Money, Requested By: illegible handwritten name. No Receipts. -2/27/24 Client #3 $120.00 Clothes, Requested By: Qualified Professional #1. No receipt. -3/7/24 Client #2 $10.00 Out to Eat, Received By: Unaudited Staff Member. No receipt. -3/11/24 Client #2 $7.36 Lunch Outing and Client #3 $7.37 Lunch Outing, Received By: Staff #6. Total disbursed $14.73. The restaurant receipt for $14.73 was dated 2/19/24. -3/13/24 Client #2 $40.00, Gardening Items, Received By: Staff #6. A receipt for peanuts and candy totaling $4.01 dated 4/1/24, a receipt for orange slices totaling $4.34 dated 4/4/24, and a receipt for Chinese food totaling $9.18 dated 3/22/24. A handwritten note by Staff #8 dated 4/8/24 claimed Client #2 bought a bag of $2.00 pork rings. No receipt -3/14/24 Client #3 $40.00 cigarettes. Requested By and Received By were left blank. No receipt. -3/25/24 a handwritten note from Staff #8 dated 3/25/24 claimed Client #2 spent a total of $23.00 on snacks and a leather wallet. No receipts.	V 542		

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V 542	Continued From page 104 -4/5/24 Client #2 $10.00 out to eat, Received By: Direct Support Supervisor. No receipt. -4/16/24 Client #2 $50.00 garden supplies, total expended $49.12, total change $.88, Received By: Unaudited Staff Member. Receipt for garden supplies totaling $17.12. A handwritten note from Staff #8 dated 4/18/24 claimed Client #2 spent $32.00 on assorted plants at a local greenhouse. No receipt. -6/5/24 Client #3 $360.00 disbursed for shopping. $269.16 expended, $90.84 change. Requested By Qualified Professional #1, Received By: illegible handwritten name. A receipt for clothing items totaling $182.50, a receipt for tobacco products totaling $48.40, a receipt for food items totaling $13.77, and a receipt for paper totaling $12.17. All of the receipts totaled $256.84 and were dated 6/24/24. -6/6/24 Client #3 $63.79 Cigarettes purchased on the house credit card. A receipt for tobacco products totaling $23.28 dated 5/20/24, a receipt for tobacco products totaling $8.96 dated 5/25/24 with the name of a sister facility handwritten across the receipt, and a receipt for tobacco products totaling $31.55 dated 6/1/24. Interview on 8/20/24 with Qualified Professional (QP) #1 revealed: -The Licensee is the payee for all clients residing at Sparta Road Home. -There were no reported or identified financial losses for the clients at Sparta Road Home.	V 542		

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Rule Violation and Client/Staff Identifier List

Facility Name: Sparta Road Home MHL Number: 097-071
Exit Date: 12/23/24 Surveyor(s): Benjamin Robinson/Maria Smith

EXIT PARTICIPANTS: LuRay Rominger (IDD Administrator), Victoria Fracassi (Qualified Professional)

COVID NOTIFICATION: In the event a COVID positive case is identified within 48 hours of a DHSR survey – the provider or DHSR should notify the other entity to prevent possible continued exposures.

Rule Violation/Tag #/Citation Level: **(no citations) – limited follow up**

Rule Violation/Tag #/Citation Level: _____

Rule Violation/Tag #/Citation Level: _____

Rule Violation/Tag #/Citation Level: _____

Client & Staff Identifier List
(Indicate staff title or number beside each name)

Client # 1 Matthew Renfro
Client # _____
Client # _____
Client # _____

Staff #1 Ben Wolfe
Staff #2 Tiffany Collins
Staff #Victoria Fracassi (Qualified Professional)
Staff #Luray Rominger (IDD Administrator)
Staff #_____
Staff #_____
Staff #_____

CITATION LEVEL: Number of days from survey exit for citation correction
Standard = 60 days **Recite** – standard = 30 days **Type A** = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

RHA
HEALTH SERVICES, LLC

December 27, 2024

MHL-097-071

Robin Sulfridge, Chief
Department of Health and Human Services
Division of Health Service Regulation Mental Health Licensure Section
2718 Mail Service Center
Raleigh, NC 27699-2718

To Whom It May Concern:

RHA Health Services NC, LLC would like to request a Petition for a Contested Case Hearing regarding Type A1 rule violations 10A NCAC 27E. 0107 Training on Alternatives to Restrictive Interventions (V536), 10A NCAC 27G. 0208 Client Services (V115) and Type A1 rule violation 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) against Sparta Road Home (MHL-097-071). As a first step in this process, we are pursuing settlement of the dispute through informal procedures.

Please find the attached copy of the Petition filed online on 12/27/2024 and the Plan of Correction for deficiencies cited during the survey completed on 12/6/2024 for your reference.

If you have any questions do not hesitate to contact me at 828-262-5450 or e-mail lrominger@rhanet.org.

Sincerely,

Luray Rominger

Luray Rominger
IDD Administrator
RHA Health Services NC, LLC

cc – Office of Administrative Hearings

cc – Ms. Julie Cronin, General Counsel @ DHHS, Office of Legal Affairs

Filed Dec 27, 2024 8:00 AM Office of Administrative Hearings

PLEASE PRINT CLEARLY OR TYPE

STATE OF NORTH CAROLINA

COUNTY OF (Wilkes)_____

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

RHA Health Services NC, LLC___

MHL-097-071 Sparta Road Home_____

PETITIONER,

v.

Mental Health Licensure and Certification Section NC Division of Health Services Regulation

_____

RESPONDENT.
(The State agency or board about which you are complaining)

PETITION FOR A CONTESTED CASE HEARING

I hereby ask for a contested case hearing as provided for by North Carolina General Statute § 150B-23 because the Respondent has:

(Briefly state facts showing how you believe you have been harmed by the State agency or board.)

On December 6, 2024 Maria Smith, Nurse Consultant I completed an annual, follow-up and complaint survey at Sparta Road Home and cited three (3) Type A1 rule violations for 10A NCAC 27E.0107 Training on Alternative to Restrictive Interventions (V536), 10A NCAC 27G.0208 Client Services (V115) and 10A NCAC 27G. 0203 Competencies of Qualified Professionals and Associate Professionals (V109). RHA Health Services NC, LLC does not agree with this decision under the listed rules and would like the opportunity to appeal this decision.

(4) Amount in controversy $ 9,000.00 (if applicable)

(If more space is needed, attach additional pages.)

(5) Because of these facts, the State agency or board has: (check at least one from each column)

_____deprived me of property;
__X__ ordered me to pay a fine or civil penalty; or
_____otherwise substantially prejudiced my rights;

AND

_____exceeded its authority or jurisdiction;
_____acted erroneously;
_____failed to use proper procedure;
__X__ acted arbitrarily or capriciously; or
_____failed to act as required by law or rule.

(6) Date: 12/24/2024 (7) Your phone number: (828) 262-5450

(8) Print your full address: RHA Health Services NC, LLC 176 Wildcat Rd. Deep Gap, NC 28618
(street address/p.o. box) (city) (state) (zip)

(9) Print your name: Luray Rominger, IDD Administrator

(10) Your signature: Luray Rominger

You must mail or deliver a **COPY** of this Petition to the State agency or board named on line (3) of this form. You should contact the agency or board to determine the name of the person to be served.

CERTIFICATE OF SERVICE

I certify that this Petition has been served on the State agency or board named below by depositing a copy of it with the United States Postal Service with sufficient postage affixed **OR** by delivering it to the named agency or board:

(11) _Ms. Julie Cronin, General Counsel__
of Legal Affairs
Raleigh, NC 27699-2001

(12) Dept. of Health and Human Services Office
(13) Adams Building 2001 Mail Service Center

(14) This the 24th day of December, 2024.

(15) Luray Rominger, IDD Administrator
(your signature)

H-06 Instructions (06/21)

When you have completed this form, you **MUST** mail or deliver the **ORIGINAL** to the Office of Administrative Hearings, 1711 New Hope Church Road, Raleigh, NC 27609.