STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G080	A. BUILDING _____ B. WING _____	C 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS I GROUP HOME	1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation survey was completed on 10/21/24 for Intake # NC00222851 and Intake # NC00222856. The complaint was unsubstantiated, and deficiencies were cited.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that management was notified immediately of allegations of mistreatment, neglect or abuse. This affected 5 of 5 audited clients (#1, #2, #3, #4 and #5). The finding is: Review of records on 10/21/24 revealed one North Carolina Incident Response Improvement System (IRIS) report for each audit client regarding an incident which was alleged to have occurred on 10/3/24. The reports indicated they were submitted on 10/4/24 and that management was made aware of the allegations on 10/3/24. Initial statements were gathered by the Residential Manager (RM) on 10/3/24 and 10/4/24. These statements were written by staff A, staff B, staff C, staff D and staff E. None of the initial statements indicated a date on which the acts complained of allegedly occurred. Continued record review revealed that The LTSS System Coordinator (hereinafter "investigator")	W 153	• Residential Team Leader will retrain staff on the oncall policy and procedures. • Residential Team Leader will ensure that the Monarch investigation policy is followed as written. • Statewide ICF Director will in-service Residential Team Leader and Residential Manager on the investigation policy. • Residential Team Leader will retrain all staff on Monarchs Investigation Policy. • Residential Team Leader and Residential Manager will complete random shift observations 2X weekly and document on a shift observation form for the next 2 months. Targeted Completion Date: 11/30/2024 RECEIVED NOV 5 2024 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kevin Clark, Statewide ICF Director — 10/31/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 interviewed each of the referenced staff regarding the allegations. When asked when the allegations occurred, staff D stated she did not recall specifically but later stated if would have been either 9/15/24 or 9/29/24. When asked when the allegations occurred, staff E stated, "It was just general like these are things that have been ongoing for a bit of a time." When asked when the allegations occurred, staff D stated she did not recall specifically but later stated it would have been either 9/15/24 or 9/29/24. When asked when the allegations occurred, staff C stated she did not recall specifically but stated, "It was like early September." Staff A is the alleged perpetrator and denied the allegations entirely. Interview with the investigator on 10/21/24 revealed that she was unable to identify a particular date on which the alleged acts occurred. Continued interview with the investigator confirmed staff are obligated to report allegations of abuse, neglect or exploitation immediately and that she will recommend training in the area of client protections and the duty to report. However, as of the 10/21/24 survey, no staff training has occurred.	W 153		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to report the results of a 10/4/24 investigation of emotional abuse to the administrator or to the Health Care Personnel	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 156	Continued From page 2 Registry (HCPR) within 5 business days as required by state law. The finding is: Record review on 10/21/24 revealed an investigation dated 10/4/24 of an allegation of verbal abuse. No documentation was provided by the facility to show the results of the investigation. Further review revealed that the investigation was started on 10/4/24 by the Qualified Intellectual Disability Professional (QIDP) who secured statements from staff in the home. Interview on 10/21/24 with the LTSS System Coordinator (hereinafter "investigator") revealed that she was not assigned to lead this investigation until 4 days later and the investigator was not able to start her part of the investigation until 4 days after that. As the 5 day requirement for completion of investigation had passed, additional time was requested from the administrator to complete the investigation. Continued interview with the investigator confirmed that the results of the investigation had not yet been reported to administrator or HCPR as required as of 10/21/24. Subsequent interview with the investigator did not reveal any extenuating circumstances occurring with this investigation that resulted in the need to extend the investigation longer than 5 days and no reason the results of the investigation were finalized and reported to the administer and HCPR as of the 10/21/24 survey, 17 days after the allegations were made and the investigation was started.	W 156	Due to late reporting: • Residential Team Leader will retrain staff on the oncall policy and procedures. • Residential Team Leader will ensure that the Monarch investigation policy is followed as written. • Statewide ICF Director will in-service Residential Team Leader and Residential Manager on the investigation policy. • Residential Team Leader will retrain all staff on Monarchs Investigation Policy. • Residential Team Leader and Residential Manager will complete random shift observations 2X weekly and document on a shift observation form for the next 2 months. • If it becomes apparent that an internal investigation is going to last longer than 5 business days, Statewide ICF Director will contact Incidents and Complaints Specialist to request an extension in the IRIS report. ICF Director will follow up with person conducting internal investigation to inquire about the status of completion of the investigation. ICF Director will maintain contact with person conducting the investigation to inquire status of the investigation that is being investigated. Targeted Completion Date: 11/30/2024	