STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-401	A. BUILDING: _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-POWELL	2250 BALTIC STREET GASTONIA, NC 28054

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DHSR-MH Licensure Sect

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on November 26, 2024. One complaint was substantiated (intake #NC00221619) and one complaint was unsubstantiated (intake #NC00221582). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 1 current client.	V 000	Monarch acknowledges that this incident was not handled appropriately or according to Monarch policy and standards. Monarch assumed UMAR services and incorporated them as a department into the agency structure. At that time these particular homes had a COO, VP of Operations, and a Residential Director. When this incident occurred, the investigative process was implemented by the VP of Operations. The VP did not follow Monarch's policies and leadership did not respond to QM request for information and follow-up. When this was discovered Monarch staff stepped in, completed the investigation, and the employee was separated from the agency. In September 2024 the UMAR homes were incorporated into the LTSS structure for the agency and placed under new leadership. The previous leadership team was dissolved. Since that time these facilities have been trained and are following the incident and investigation process. Monarch employes two (2) full-time positions who conduct internal investigations and work with QM to thoroughly review each incident and document their findings. Investigation findings and recommendations made by the investigator positions are reviewed by Monarch's internal review team which consists of QM, HR, and LTSS leadership staff. We feel at this time we have corrected all the events that led to this situation and deficit.	
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.	V 132		

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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Omar Polk BA, QP — Residential Director — 12/18/2024

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V 132	Continued From page 1 e. Fraud against a health care facility or against a patient or client for whom the employee is 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 protect the clients during an investigation of abuse, neglect or exploitation. The findings are: Review on 10/22/24 of the facility's incident reports from 8/1/24 through 10/21/24 revealed: -On 8/11/24 Client #1 told Staff #4, FS #1 dropped her while transitioning her (Client #1) from her bed to her wheelchair and FS #1 cursed at her. Review on 10/23/24 of a document titled "Internal Investigation Report" revealed: -The internal investigation began on 8/12/24 and ended on 10/11/24. -FS#1 was not suspended due to the allegations made by Client #1 and continued to work on 8/13/24. -FS #1 was moved to a another facility on 8/13/24. Interview on 10/24/24 with the Facility System Coordinator revealed: -The VP was not aware FS #1 could not work with any clients. -"The VP was not aware [FS #1] was supposed to be suspended until the internal investigation was	V 132		

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V 132	Continued From page 2 completed."	V 132	Monarch acknowledges that this incident was not handled appropriately or according to Monarch policy and standards.	
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations of abuse affecting 1 of 1 Former Staff (FS #1). The findings are: Review on 10/24/24 of FS# 1's personnel file revealed: -Hire date of 4/1/24. -Separation date of 10/11/24. -Job title of Creative Arts Specialist. Review on 10/22/24 of the facility's incident reports 8/1/24 through 10/21/24 revealed:	V 318	Monarch assumed UMAR services and incorporated them as a department into the agency structure. At that time these particular homes had a COO, VP or Operations, and a Residential Director. When this incident occurred, the investigative process was implemented by the VP of Operations. The VP did not follow Monarch's policies and leadership did not respond to QM request for information and follow-up. When this was discovered Monarch staff stepped in, completed the investigation, and the employee was separated from the agency. In September 2024 the UMAR homes were incorporated into the LTSS structure for the agency and placed under new leadership. The previous leadership team was dissolved. Since that time these facilities have been trained and are following the incident and investigation process. Monarch employes two (2) full-time positions who conduct internal investigations and work with QM to thoroughly review each incident and document their findings. Investigation findings and recommendations made by the investigator positions are reviewed by Monarch's internal review team which consists of QM, HR, and LTSS leadership staff. We feel at this time we have corrected all the events that led to this situation and deficit.	

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V 318	Continued From page 3 -On 8/11/24 Client #1 told Staff #4, FS #1 dropped her while transitioning her (Client #1) from her bed to her wheelchair and FS #1 cursed at her. -Staff #4 reported the allegations made by client #1 to the House Manager on 8/11/24. Review on 10/24/24 of the North Carolina Incident Response Improvement System (IRIS) from 8/11/24 to 10/1/24 revealed: -No report of FS #1 cursing at Client #1 completed until 8/30/24. Interview on 10/24/24 with the Facility System Coordinator revealed: -She updated NC IRIS to reflect Client #1 reported that FS #1 cursed at her. -Notified HCPR on 8/30/24.	V 318		