STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-654	A. BUILDING: _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERVANT'S HEART	3706 OLD BATTLEGROUND ROAD GREENSBORO, NC 27410

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V 132	Continued From page 1 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 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 review and interview, the facility failed to make every effort to protect clients from harm during an investigation into an alleged act of abuse. The findings are: Review on 1/13/25 of staff #1's record revealed: - A hire date of 10/21/24 - Hired as a Direct Support Professional (DSP) Review on 1/23/25 of client #1's record revealed: - An admission date of 4/5/24 - Diagnoses of Ototoxic Hearing Loss, Bilateral; Intellectual Disability (Intellectual Developmental Disorder), Severe - 24 years of age Review on 1/23/25 of an email sent by Former Staff 5 (FS #5) to the Director on 1/13/25 revealed:	V 132	Henceforth, if any staff is accused of abuse or neglect, including: 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 carefacility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services) that staff will immediately be removed from the schedule and placed on leave until the conclusion of an internal investigation.	

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V 132	Continued From page 2 - "...I am writing to formally report a serious incident of client abuse that occurred at our workplace on 01-09-2025 by [staff #1], which some employees witnessed and were present in the area. During the departure time, unsure of exactly what initiated the situation, but it resulted in [staff #1] returning back in the building admitting to punching a client by the name of [client #1] in the face..." - FS #5 requested an "immediate investigation" into the events of 1/9/25 as "...I am deeply concerned about the well-being of [client #1] and other clients who may be exposed to similar treatment..." Review on 1/23/25 of an "Internal Investigation Report" completed and signed and dated 1/15/25 by the Director revealed: - The internal investigation began on 1/13/25 and was completed on 1/15/25 - No evidence staff #1 was placed on suspension while the internal investigation was ongoing Interview on 1/27/25 of staff #1 revealed: - She was not suspended from her position as a DSP while she was being investigated for allegedly "punching" client #1 in the face on 1/9/25 Interview on 1/27/25 and on 1/31/25 with the Director revealed: - Confirmation staff #1 had not been placed on suspension while she was being investigated for the alleged abuse of client #1 - Did not realize staff #1 should not have continued to work at the facility while under investigation - The Day Program Director and the Qualified Professional had "monitored" staff #1 when she	V 132		

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V 132	Continued From page 3 was at work at the facility - No other incidents had occurred between staff #1 and client #1 when staff #1 was duty at the facility	V 132		
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 review and interview, the facility failed to notify the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of any allegation of abuse affecting 1 of 1 audited staff (#1). The findings are: Review on 1/13/25 of staff #1's record revealed: - A hire date of 10/21/24 - Hired as a Direct Support Professional (DSP) Review on 1/23/25 of client #1's record revealed:	V 318	Administrators and supervisors were re-trained on 2/5/25 regarding proper reporting on member crisis and staff behaviors. Supervisors were instructed to immediately report any statements of harm or allegations of abuse or neglect to their supervisor and submit an IRIS within 24 hours of the incident. These protocols will be reviewed quarterly during regularly scheduled adminsitrative meetings	

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V 318	Continued From page 4 - An admission date of 4/5/24 - Diagnoses of Ototoxic Hearing Loss, Bilateral; Intellectual Disability (Intellectual Developmental Disorder), Severe - 24 years of age Review on 1/23/25 of a report completed and submitted by the Director to the Incident Response Improvement System (IRIS) on 1/13/25 revealed: - The date and time of the incident was documented as having occurred on 1/9/25 at 3:15 pm - The narrative revealed: "On Thursday (1/9/25) [client #1] was standing at the side exit of the day program. A staff [staff #1] walked past [client #1] towards her car. [Client #1] runs up behind [staff #1] and hits her on the head with her fist and then grabs her tobaggan. [Staff #1] turns around to see what is going on. In the process of turning around, the book bag she was caring falls down her shoulder to her elbow, The book bag appears to make contact with [client #1.]. When [staff #1] has turned around and sees it was [client #1] who hit her, she continues to walk to her car. She drops off her book bag at her car and begins to walk back into the building. [Client #1] meets her halfway and continues to loudly vocalize in [staff #1's] face. [Client #1] aggressively signs and yells at [staff #1] as she walked into the building. All of this was documented via an internal incident report on 1/9/25. [Client #1's] team was alerted that day as well..." Review on 1/27/25 of an in-house incident report signed and dated 1/9/25 by staff #1 revealed: - The "event type" was listed as "assault" with staff #1 listed at the "victim" of a "physical assault."	V 318		

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V 318	Continued From page 5 - The incident report revealed "[Client#1] was standing outside vocalizing and displaying aggression towards staff. [Staff #1] walked out of the side door to leave for the day when [client #1] ran up behind [staff #1] and hit her in the back of the head. [Staff #1] turned around and moved in attempt to avoid another hit. [Staff #1] walked to her car to put stuff down and returned into the building to let admin (administration) know what happened. [Client#1] continued to walk up on [staff #1] in an aggressive manner. After [staff #1] made admin aware she walked away and left for the day." - No other information regarding the incident was listed in the report Interview on 1/27/25 with staff #1 revealed: - On 1/9/25, as she walked out of the facility, she observed client #1 standing outside near a facility vehicle - Client #1 was "fussing" (using sign language in a "fast" manner and "yelling"); however, these behaviors were not directed towards anyone special - Did not engage with client #1; however, as she continued to walk away from the facility, client #1 walked up behind her and "grabbed her by the back of her head." - When she turned around to see who had "grabbed" her, the bag she was carrying, "came off my arm and hit [client #1]." - Believed the bag "hit" client #1 in her face, "because she was holding her eye." - After the encounter, client #1 was "making sounds and signing." - Knew some sign language; however, she did not know what client #1 was saying at that time - Walked to her vehicle to put away her belongings and then walked back towards the facility	V 318		

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V 318	Continued From page 6 - As she walked towards the facility, client #1 walked towards her, continuing to "sign and make noises"; however, she did not engage with her but instead continued walking towards the facility - Once back inside the facility, she "blurted out, Oh my gosh, I think I hit her (client #1)" Believed the Day Program Director (DPD); the Qualified Professional (QP) and staff (#2 and #3) were present when she made the statement - Without speaking to anyone any further, she left the facility - Received a telephone call from the DPD later that same day with the DPD telling her that her "words were alarming" and she needed to complete an in-house incident report regarding the matter - Completed an in-house incident report and had since spoken with the DPD, and the QP (no date provided) and met with the Director on 1/13/25 regarding the matter - The bag she was carrying struck client #1; she did not "hit" client #1 - Never disclosed to anyone she "punched" client #1 on 1/9/25 or since then - Received a "write up" for not responding well to a client while they are in crisis mode." - Scheduled to re-take North Carolina Interventions (NCI) training (on the proper use of restraints/releases) on 2/20/25 - Neither she nor client #1 sustained any injuries as a result of the incident on 1/9/25 - There have been no other incidents between her and client #1 since 1/9/25 Interview on 1/23/25 with the DPD revealed: - On 1/9/25, she was in the bathroom at the time of the incident between staff #1 and client #1 - While in the bathroom, she heard staff #3 "screaming" that client #1 was outside "hitting [staff #1] in the back of the head."	V 318		

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V 318	Continued From page 7 - Observed staff #1 come back inside the facility and report she had "hit [client #1}." - When staff #1 left before she could meet with with her, she reviewed the video footage of the incident between client #1 and staff #1 - When she reviewed the video, it appeared that as staff #1 walked away from the facility, client #1 "grabbed" staff #1 by the head - When staff #1 turned around to see who had "grabbed" her head, the bag she was carrying made contact with client #1 - It did not appear that staff #1 had intentionally struck client #1 or caused any harm to client #1 - Instructed staff #1 an in-house incident report would need to be completed regarding the matter Interview on 1/31/25 with the Director revealed: - The DPD did not inform her on 1/9/25, staff #1 had reported she "hit" client #1 during an encounter that occurred between the two of them earlier that day - Received an email on 1/13/25 from Former Staff #5 who reported that on 1/9/25, she overheard staff #1 state she "punched" client #1 - Immediately initiated an internal investigation on 1/13/25 regarding the concerns listed in the email and submitted an IRIS report which included notification to the HCPR - Would have initiated an internal investigation and made the required notification to the HCPR on 1/9/25, if she had been made aware of staff #1's statement	V 318		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT	V 537		

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V 537	Continued From page 8 (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene	V 537		

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V 537	Continued From page 9 (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (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 Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence	V 537		

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V 537	Continued From page 10 by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.	V 537	Type text here	

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V 537	Continued From page 11 (1) Documentation shall include: (A) who participated in the training and the outcome (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. (l) 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. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 1 staff (staff #1) demonstrated competency in the proper use of restrictive interventions. The findings are: Observation on 1/23/25 at 2:11 pm of video footage recorded on 1/9/25 revealed: - On 1/9/25 at 3:15 pm, as staff #1 walked out of the facility, client #1 came up behind her and took staff #1's head into her hands - Staff #1 was observed to be wearing a hood on her head at the time when client #1 took her head into her head from behind - When staff #1 turned around to see who had grabbed her head, staff #1's arm, her elbow or	V 537	The staff who failed to properly react to a member in crisis was immediately placed into the next available NCI+ training. The staff's personnel record will be updated with her additional certification after the completion of the training.	

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V 537	Continued From page 12 the tote bag she was carrying struck client #1 about the face and/or shoulders - After their encounter, staff #1 walked to her vehicle, put the bag inside the vehicle and walked back towards the facility - As staff #1 walked back towards the facility, client #1 approached her and could be seen using her arms to gesture at staff #1 - Staff #1 walked past client #1 and never stopped to engage with her nor turn around as client #1 continued to follow behind her - There was no audio associated with the video being reviewed Review on 1/23/25 of a report completed and submitted by the Director to the Incident Response Improvement System (IRIS) on 1/13/25 revealed: - The date and time of the incident was documented as having occurred on 1/9/25 at 3:15 pm - Information about the incident was reported as follows: " ..."On Thursday (1/9/25) [client #1] was standing at the side exit of the day program. A staff [staff #1] walked past [client #1] towards her car. [Client #1] runs up behind [staff #1] and hits her on the head with her fist and then grabs her tobaggan. [Staff #1] turns around to see what is going on. In the process of turning around, the book bag she was caring falls down her shoulder to her elbow. The book bag appears to make contact with [client #1.]. When [staff #1] has turned around and sees it was [client #1] who hit her, she continues to walk to her car. She drops off her book bag at her car and begins to walk back into the building. [Client #1] meets her halfway and continues to loudly vocalize in [staff #1's] face. [Client #1] aggressively signs and yells at [staff #1] as she walked into the building. All of this was documented via an internal incident	V 537		

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V 537	Continued From page 13 report on 1/9/25. [Client #1's] team was alerted that day as well..." Review on 1/23/25 of client #1's record revealed: - An admission date of 4/5/24 - Diagnoses of Ototoxic Hearing Loss, Bilateral; Intellectual Disability (Intellectual Developmental Disorder), Severe - 24 years of age Interview on 1/23/25 of client #1 via a interpreter from the Communication Services for the Deaf and Hard of Hearing (CSDHH) revealed: - Via the use of American Sign Language (ASL) the CSDHH interpreter informed client #1 who the DHSR (Department of Health Service Regulation) surveyor was and the surveyor's wish to talk with her - When asked how she was, client #1 signed she was "fine." - Did not wish to answer any more questions and signed to the CSDHH interpreter that she was "ready to leave." Review on 1/23/25 of staff #1's record revealed: - A hire date of 10/21/24 - Hired as a Direct Support Professional (DSP) - Staff #1 received training in North Carolina Intervention Plus - Restrictive (NCI + Prevention, Defensive and Restrictive) on 10/25/24 Interview on 1/27/25 with staff #1 revealed: - On 1/9/25, as she walked out of the facility, she observed client #1 standing outside near a facility vehicle - Client #1 was "fussing" (using sign language in a "fast" manner and "yelling"); however, these behaviors were not directed towards anyone in particular - Did not engage with client #1; however, as	V 537		

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	MHL041-654	A. BUILDING: _____ B. WING _____	C 01/31/2025

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V 537	Continued From page 14 she continued to walk away from the facility, client #1 walked up behind her and "grabbed her by the back of her head." - When she turned around to see who had "grabbed" her, the bag she was carrying, "came off my arm and hit [client #1]." - Believed the bag "hit" client #1 in her face, "because she was holding her eye." - After the encounter, client #1 was "making sounds and signing." - Knew some sign language; however, she did not know what client #1 was saying at that time - Walked to her vehicle to put away her belongings and then walked back towards the facility - As she walked towards the facility, client #1 walked towards her, continuing to "sign and make noises"; however, she did not engage with her but instead continued walking towards the facility - Once back inside the facility, she "blurted out, Oh my gosh, I think I hit her (client #1)" Believed the Day Program Director (DPD); the Qualified Professional (QP) and staff (#2 and #3) were present when she made the statement - Without speaking to anyone any further, she left the facility - Received a telephone call from the DPD later that same day with the DPD telling her that her "words were alarming" and she needed to complete an in-house incident report regarding the matter - Completed an in-house incident report and had since spoken with the DPD, and the QP (no date provided) and met with the Director on 1/13/25 regarding the matter - The bag she was carrying struck client #1; she did not "hit" client #1 - Had never disclosed to anyone she "punched" client #1 on 1/9/25 or since then - Received a "write up" for not responding well	V 537		

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V 537	Continued From page 15 to a client while they are in crisis mode." - Scheduled to re-take North Carolina Interventions (NCI) training (on the proper use of restraints/releases) - Neither she nor client #1 sustained any injuries as a result of the incident on 1/9/25 - There have been no other incidents between her and client #1 since 1/9/25 An attempt to interview staff #2 on 1/23/25 was unsuccessful as staff #2 refused to be interviewed An attempt to interview staff #2 on 1/27/25, the DHSR surveyor provided staff #2 with the surveyor's telephone number; however, no phone call was received from staff #2 prior to the close of the survey on 1/31/25. Interview on 1/23/25 with staff #3 revealed: - On 1/9/25, she was standing at the side door of the facility watching clients being "loaded up on the van." - As staff #1 was leaving work for the day and walking away from the building, client #1 "came up from behind her (staff #1) and took her hands and shook [staff #1's] head." - Staff #1 used her hand and "pushed" client #1's arm down - Never saw staff #1 or any object strike client #1 in the face or any other part of her body - She turned away from the door and did not observe anything else happen between staff #1 and client #1 while they were outside - Staff #1 later returned inside the facility and stated, "Y'all better get her, because she is out there putting her hands on people." - Never observed staff #1 to be inappropriate with any clients	V 537		

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V 537	Continued From page 16 Interview on 1/27/25 with staff #4 revealed: - Did not see the alleged incident between staff #1 and client #1; however, she did review the video of the incident - In the video, staff #1 could be seen walking away from the facility when client #1 "grabbed her by the head." - "[Client #1] yoked up (caused injury) [staff #1]." - Was an "unexpected" action by client #1 and "[Staff #1] was caught off guard." - Staff #1 "swung around" and the bag she was carrying struck with client #1 - Overhead staff #1 state, "She may have hit client #1 in the face with her bag." - Did not believe staff #1 would purposefully strike client #1; however, in this instance, it was just a "reflex" her part because she was "startled" and "caught off guard" by client #1's action - Client #1 "attacked her (staff #1) from behind." - Staff #1 left the facility without talking to anyone else to provide any additional details - Believed the DPD contacted the Director on 1/9/25 to inform her of the incident Interview on 1/23/25 with the DPD revealed: - On 1/9/25, she was in the bathroom at the time of the incident between staff #1 and client #1 - While in the bathroom, she heard staff #3 "screaming" that client #1 was outside "hitting [staff #1] in the back of the head." - Observed staff #1 come back inside the facility and report that she "hit [client #1}." - When staff #1 left without any further discussion; she reviewed the video footage of client #1 and staff #1 - When she reviewed the video, it appeared that as staff #1 walked away from the facility, client #1 "grabbed" staff #1 by the head	V 537		

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V 537	Continued From page 17 - When staff #1 turned around to see who had "grabbed" her head, the bag she was carrying, made contact with client #1 - It did not appear that staff #1 struck client #1 intentionally nor caused any harm to client #1 - She did not speak with staff #1 until 1/13/25 (the facility was closed on 1/10/25 due to inclement weather)and had her complete an in-house incident report - Staff #1 received a written disciplinary action because she did not follow her NCI training on how to properly free yourself if someone should grab you by the head - One should "dip your head and move away from the client" instead of how staff #1 responded - In NCI training, you are "taught to twist around and move away from the person." - Staff #1 was scheduled to receive a refresher training in NCI soon Interview on 1/31/25 with the Director revealed: - Initiated an internal investigation on 1/13/25 of the alleged abuse of client #1 by staff #1 on 1/9/25 - The investigation was completed on 1/15/25 - The conclusion of the agency's administrative team's was that staff #1 had not physically abused client #1 but instead failed to follow proper North Carolina Interventions (NCI) protocol on how to address a client when they were in crisis - Staff #1 did not realize it was client #1 who "grabbed" her head and her actions were a "reflex" as she was attempting to protect herself - Felt it was important to acknowledge that once staff #1 was free from client #1's grasp of her head, she did not engage with client #1 anymore but instead went back inside of the facility to report to the administrative staff what had happened	V 537		

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V 537	Continued From page 18 - No other incidents had occurred between staff #1 and client #1 since 1/9/25 - Staff #1 was enrolled in a refresher class in NCI training to be held in February 2025	V 537		