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V 000	INITIAL COMMENTS An annual survey was completed on March 14, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
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 (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.	V 112		

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This Rule is not met as evidenced by:
Based on record review, observation, and interview, the facility failed to develop and implement treatment strategies for 1 of 2 clients (Client #2). The findings are:

Review on 3/12/25 of Client #2's record revealed:
-Admission date of 11/8/19.
-Diagnoses of Autistic Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Moderate Intellectual Developmental Disorder, Anxiety Disorder, Chronic Cluster Headache, Restlessness and Agitation, and Jaw Pain.
-Client #2 was non-verbal.
-Review on 3/12/25 of Client #2's 10/1/24 treatment plan revealed:
-" ... if given the chance, I am going to run and try to elope. I am quick and can be gone in a minute."
-"... because of my size and my unawareness of personal space and boundaries, I can be very intimidating to those that don't know me and (I) have charged at people while out in the community."
-"I currently have alarms on the windows and doors, also locks are in place on all outside doors ...These have been reviewed and approved by the human rights committee."
-"I have significant self-injurious behaviors (SIB) and others (staff) must physically intervene by placing pillows, and other soft items to prevent

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me from injuring myself from head banging and other self-injurious behavior."
-"Remember when redirecting me or helping me calm down I feed off your emotions, so it is important to remain calm and speak in an even tone voice."
-"Transitions from the house to car and car to house are very hard for me... It is important to always have an additional staff in the car with me..."
-"What does a crisis look like for me? I will holler ...or bite myself. My face will get red, I will throw myself to the floor, scream, bang my hands to my jaw, become physically aggressive, hit, pinch, bite, shove people, destroy property."
-No documentation of treatment goals and strategies that addressed Client #2 eating non-food items.
-No documentation of treatment goals and strategies that addressed Client #2's urination and defecation in places other than the toilet.

Review on 3/12/25 of Client #2's 12/23/24 behavior support plan revealed:
-Client #2 had targeted behaviors of SIB of biting self and hitting or slapping head, disruptive behaviors of running around the facility with high intensity and throwing objects, and elopement.
-Defecation in places other than the toilet was listed as a tracking behavior
-Precursor behaviors included "hollering" into hands, pacing, jumping up and down.
-"The severity/intensity of [Client #2]'s target behaviors are consistently severe (i.e., represent imminent risk of significant harm to self or others)."
-Treatment strategies included:
-Offer Client #2 the opportunity to be removed from an overstimulating environment. An alternative was to offer Client #2 a distracting

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activity such as a sensory item, snack, drink, or sensory toy.
-"Always use a calm and matter of fact tone of voice when talking to [Client #2]."
-If use of a calm voice was not effective, "prompt [Client #2] to give you (staff) a 'high five' from a safe distance."
-"Use the minimum amount of language possible when interacting with [Client #2] when he is anxious or upset."
-"Implement environmental controls (e.g., lock on refrigerator/cabinets) as necessary to ensure [Client #2]'s safety."
-"Ensure that locks or other modification (e.g., food placed in refrigerator in restricted area of home (facility) are implemented to ensure [Client #2] does not engage in eating behaviors that could place his safety at risk."
-"Ensure alarms are placed on external doors to [Client #2]'s home (facility), as well as on windows in [Client #2]'s bedroom."

Review on 3/12/25 of incident reports for the period of 1/1/25 to 3/12/25 revealed:
-All incidents were Level I reports.
-The reports were for Client #2.
-There was no documentation that both AFL Provider #1 and AFL Provider #2 were present during each incident.
-In January 2025, Client #2 had the following incidents:
-1/5/25 at 4:45 pm, Client #2 "ran" outside the facility unclothed while AFL Provider #1 had turned to grab a towel while he showered. AFL Provider #1 "proceeded to quickly guide [Client #2] back into the house (facility) as it was cold outside."
-1/6/25 at 4:30 pm, Client #2 "walked" out of the facility through the back door and "ran" to a neighbor's property with AFL Provider #2 having

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redirected him back to the facility.
-1/7/25 at 6:30 pm, Client #2 "opened up the kitchen window and put half his body through the window" while AFL Provider #1 was going "back and forth" between the kitchen and Client #2's room.
-3/11/25 at 5:45 pm, Client #2 was in the living room with his toys when he "eloped while staff (AFL Provider #2) was using the bathroom." There was no documentation how long Client #2 was gone from the facility.

Observations on 3/11/25 between 4:00 pm-5:00 pm of Client #2 revealed:
-Clients #1 and #2 were present in the backseat of a car with 1 AFL Provider (AFL Provider #2) as they arrived at the facility.
-At approximately 4:05 pm, Client #2 walked to a neighbor's property on the right side of the facility with his pants falling down. Prior to this behavior, Provider #2 verbally prompted Client #2 to stop hitting the front porch post with his hands and come inside. AFL Provider #2 ran after Client #2 and walked him back to the facility.

Observation on 3/12/25 between 7:00 pm- 8:30 pm of Client #2 revealed:
-AFL Provider #1 was preparing dinner for Clients #1 and #2 while Client #2 was continually pacing through the facility from his bedroom, into the living room, and into the kitchen with Staff #3 following him.
-Client #2 made loud audible sounds as he paced inside the facility.
-When Client #2 sat down in the living room chair, the Associate Professional (AP) stood in front of him, clapping her hands loudly toward Client #2 and repeatedly asked if he wanted to get up and dance. Client #2 responded by slapping each side of his head with his hands followed by biting his

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top right hand.
-The AP did not physically intervene to place a pillow or other soft object near Client #2's head to prevent him from injury as he slapped each side of his head.
-Client #2 had skin discoloration on each side of his head at his hairline above his ears.
-Client #2 walked into the kitchen, opened the unlocked refrigerator door, and ate a piece of raw sausage with the Qualified Professional (QP), the AP, and AFL Provider #1 present in the kitchen. He then opened up a kitchen door to where snacks were stored and got himself a snack.
-Client #2 walked into an unlocked storage room that stored non-perishable food items and miscellaneous facility decorations and household supplies. Client #2 sat on the floor next to a table with the non-perishable food items as the AP stood over him and gave verbal prompts for him to get up and leave the room.

Observation on 3/12/25 between 3:16 pm-3:47 pm of the facility revealed:
-No alarms or sensors on Client #2's bedroom window or on the front and back doors.
-The lock on the refrigerator and freezer door handles was missing.
-An interior door which led to a room where a supply of nonperishable foods was locked.
-The unlocked linen closet in Clients #1 and #2's bathroom contained a pink bottle of baby lotion.
-The facility is located at the top of a cul-de-sac within a housing development with approximately 4-5 houses from the stop sign at the intersection of the cul-de-sac and another road.

Interview on 3/12/25 with AFL Provider #1 revealed:
-She and AFL Provider #2 "are always with him (Client #2)."

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V 112	Continued From page 6 -She followed Client #2 when he ran away from the facility. He "has not run off where you couldn't find him." -"We keep it (the refrigerator) locked. He (Client #2) always wants to go in there and he will scatter everything in the refrigerator." Interviews on 3/11/25 and 3/12/25 with AFL Provider #2 revealed: -Client #2 had difficulty with transitions, especially when he transitioned from a vehicle to inside the facility when he returned from school. -"He (Client #2) leaves the house when the door is open and goes to the neighbor's house. We (AFL Providers #1 and #2) walk up to him and tell him to come back home (facility). He doesn't refuse to come back home (facility)." -"He has walked to the stop sign or to a neighbor's house." -" ...a couple of months ago, he walked out of the house naked ...a neighbor called social services. [AFL Provider #1] was on staff. I was not here. I had time off." -"The lock was on the refrigerator because [Client #2] will get in there and mix foods together and destroy the food. Snacks are kept in the garage. No foods are kept in the kitchen cabinets. They (non-perishable foods) are in the garage." -"He (Client #2) stuffs his mouth with food ...he likes to eat raw food." -"He tries to eat other things, not food but like [brand name] baby lotion. He licks it out of his hand like yogurt." Interview on 3/12/25 with the Associate Professional (AP) revealed: -She provided support to the QP with office duties and supported Client #2 with his treatment plans. -She worked as a fill-in staff on 2nd shift one to two days a week and did not work an overnight	V 112		

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shift.
-Client #2 "needs full care, he's strong and requires a lot (of care). He will use the bathroom on himself. Staff (AFL Providers #1 and #2) try to prompt him to use the toilet."
-"He can't do any of his activities of daily living (ADLs) independently. He will run around the house (facility) and unclothe himself. We (she and AFL Providers #1 and #2) try to reclothe him."
-"He (Client #2) doesn't understand transitions (from one activity to another) and not being allowed to have what he wants."
-"There has to be 2 staff in the van when transporting the clients (Clients #1 and #2)."
-Client #2's care team, guardian, behavior specialist, AFL Providers #1 and #2, QP and the Chief Executive Officer (CEO), have talked about the need to fund a fence for the sides and back of the facility.
-"A fence or a security system would help increase [Client #2]'s safety by slowing him down. There's also an idea about floor mats with a sensor that will go off when [Client #2] gets closer to the door. He doesn't like change though. He will take an object and destroy it."
-The behavior specialist visited the facility once a month, making sure they (AFL Providers #1 and #2) understood how to work with Client #2 on his goals.

Interview on 3/12/25 with the QP revealed:
-"[Client #2] is bigger and stronger but his behaviors are consistent. His head banging ...when he's involved in SIB, he doesn't want anyone to intervene."
-Adult Protective Services (APS) visited the facility a couple of days after Client #2 ran outside unclothed and a neighbor called in a report to social services. "We went through the process, showed his (behavior) plan and targeted

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behaviors, (we) told what happened ...nothing happened from there (outcome of the APS investigation)."
-"(Client #2) loves to take his clothes off" and identified this behavior as one of his targeted behaviors.
-"Neighbors have threatened to kill him, hurt him (Client #2) because he goes into neighbors' yards."
-Client #2 was "into eating raw foods" the reason there was a lock on the refrigerator door handles and on the garage door.
-Client #2 "has short sleeps so staff have to be awake. He wakes up and plays with his toys and will come into the kitchen and get into the refrigerator. He sleeps 2 ½ hours at night."
-No sensors or alarms were on Client #2's window and the front and back doors because Client #2 would remove the sensors.
-Client #2 had incidents in which he urinated and "even squatted on the living room floor and had bowel movements."
-"[AFL Providers #1 and #2] are supposed to take him (client #2) to the bathroom every 2 hours if they can get him to go. He refuses sometimes."
-Client #2 had adult pullups to wear but did not wear them because he tore the pullups up.

Interview on 3/13/25 with Client #2's behavior specialist revealed:
-He worked with Client #2 in 2019 when he lived with his mother and she was unable to control Client #2's behavior.
-He visited Client #2 at the facility each month and met with AFL Provider #1 or #2.
-"I am trying to get things (strategies) implemented but it seems nothing is getting done. Staff (AFL Providers #1 and #2) seem overwhelmed with (Client #2)'s behaviors;" he was trying to implement one strategy at a time

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with each AFL Provider.
-The strategies he trained the AFL Providers on included decreasing their language with Client #2 by having them use visual cues to engage him with a tangible object instead of a behavior, verbally communicating with him by talking slower and using simple words, and asking Client #2 for a "high five" with a visual cue to disrupt his SIB.
-Client #2's team met this morning and he learned the CEO had issued a 60-day discharge notice for Client #2 and then as of the previous night (3/12/25) issued Client #2 a 72-hour discharge notice.
-"Now he's (Client #2) much bigger (in size) and (physically) stronger ... for him to return home to his mother would be unsafe for both of them ..."
-"I have discussed with the provider (CEO) alternatives to window sensors due to the concern [Client #2] would remove the sensors. Other alternatives have been to install a floor mat in front of the doors that sounds an alarm, delayed door locks, and installation of partial fencing on the sides and back of the house (facility) that would serve to delay him (Client #2) going into the neighbors' yards."
-He understood from the CEO that an enhanced rate of pay was needed for the facility to implement these strategies.

Interviews on 3/12/25, 3/13/25 and 3/14/25 with the CEO revealed:
-The behavior specialist "just started working back with [Client #2]" (date unknown) and he visited with Client #2 monthly at the facility.
-She confirmed the 72-hour discharge notice was issued to Client #2's guardian.
-"I know I can keep him safe and protect him."
-She had an alarm installed on Client #2's bedroom window this morning (3/13/25).
-On 3/13/25, she rescinded the 72-hour discharge

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for Client #2 but kept the 60-day discharge notice in place.
-She planned to have the behavior specialist provide formal training to her and her staff on Client #2's behavior support plan.
-"Sometimes I don't know all the details myself. I need the training and be familiar with all the (treatment) plans."

Review on 3/12/25 of a Plan of Protection dated 3/12/25 and completed by the CEO revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? [Licensee] will ensure that there are 2 staff available to care for client #2 starting 3/12/25 and moving forward. RCA (Residential Care Academy) will ensure that there are always 2 staff supporting client #2 during awake and sleep hours and during car ride. Alarms will be installed on client #2 window and door effective tomorrow, 3/13/25. A 60 days' notice discharge was issued today,3/12/25 to his guardian and the LME/MCO.

-Describe your plans to make sure the above happens. RCA, CEO, QP and residential director will follow up with the staff to ensure the POP is followed thoroughly tonight. Additionally, the Residential Director will monitor the group home cameras as an extra layer of safety and to monitor staff interaction with client #2."

Review on 3/14/25 of a second Plan of Protection dated 3/14/25 and completed by the CEO revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? 1.Royal Child (Licensee) will ensure that there are 2 staff available to care for client #2 starting 3/12/25 and moving forward. RCA will ensure that there are always 2 staff supporting client #2

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V 112	Continued From page 11 during awake and sleep hours and during car ride. 2. Alarms will be installed on client #2 window and door effective tomorrow, 3/13/25. A 60 days' notice discharge was issued today,3/12/25 to his guardian and Partners. 3. All Staff including drivers will be trained on client #2 BSP and ISP 4.Staff will be closely monitored to ensure client #2 treatment plan is being followed 5. Management will visit the home 2 to 3 times a week to supervise staff. 6. CEO will learn more about client # 2 BSP and ISP to be able to provide quality support and supervision 7. Royal Child will organize staff training with [the behavior specialist] once a month. -Describe your plans to make sure the above happens. 1.RCA CEO, QP and Residential director will follow up with the staff to ensure the POP is followed thoroughly. 2.Additionally, the Residential Director will monitor the group home cameras as an extra layer of safety and to monitor staff interaction with client #2. 3.[The behavior specialist] will train staff immediately 4. There will be an ongoing training for staff every week until staff are very familiar with treatment plan and ISP (Individual Support Plan) then it will be reduce to once a month. This will be done by the QP and the Residential Director 5. CEO will join trainings and will do follow up to ensure that Client #2 is receiving proper treatment 6. QP ,Residential director and CEO will ensure that the BSP and the ISP for client #2 is being used for the treatment of client #2 at all times by	V 112		

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V 112	Continued From page 12 all staff." An addendum to the second Plan of Protection dated and completed on 3/14/25 by the CEO revealed: -Dates were added to the following numbered actions under "What immediate action will the facility take to ensure the safety of the consumers in your care? ... 3. All Staff including drivers will be trained on client #2 BSP and ISP by 3/28/2025 4.Staff will be closely monitored to ensure [Client #2] treatment plan is being followed starting 3/14/2025 and will be ongoing 5. Management will visit the home 2 to 3 times a week to supervise staff. 3/18/2025 and 3/21/2025 and ongoing 6. CEO will learn more about client # 2 BSP and ISP to be able to provide quality support and supervision 3/17/2025 7. Royal Child will organize staff training with [the behavior specialist] once a month. By 4/26/2025." -Dates were added to the following numbered items in "Describe your plans to make sure the above happens. 3. [The behavior specialist] will train staff immediately by 3/28/2025 4. There will be an ongoing training for staff every week until staff are very familiar with treatment plan and ISP then it will be reduce to once a month. This will be done by the QP and the Residential Director. Starting 3/21/2025 and ongoing." Client #2 lived at this facility for 5 years and 4 months and was diagnosed with Autistic Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Moderate Intellectual Developmental Disorder, Anxiety	V 112		

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	MHL036-366	A. BUILDING: _____ B. WING _____	03/14/2025

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V 112	Continued From page 13 Disorder, Chronic Cluster Headache, Restlessness and Agitation, and Jaw Pain. Client #2's behaviors were represented as imminent risks of significant harm to himself and others and his behaviors were overwhelming for one staff to manage. His behaviors were consistent and included hitting himself on his head, biting his hand, accessing and eating raw food, running into the facility yard unclothed and running into the neighbors' yards. There were no alarms or security sensors on Client #2's bedroom window or on the front and back doors as recommended by the behavior specialist to alert staff of Client #2's impending elopement incidents. Locks on the refrigerator door handles and food storage room were strategies in Client #2's behavior support plan but were not used consistently by AFL Providers #1, the AP and the QP which led to Client #2 accessing and eating raw sausage. Behavior strategies to be used by the facility such as limited language and a calm tone of voice were not implemented by Staff #3 on 3/12/25 as Client #2 sat in a chair hitting his head and biting his hand. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 112		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be	V 290		

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V 290	Continued From page 14 present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.	V 290		

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V 290	Continued From page 15	V 290		

This Rule is not met as evidenced by:
Based on record reviews, interviews, and observation, the facility failed to ensure staffing to meet the individualized needs of the clients served. The findings are:

Review of Client #1's record on 3/12/25 revealed:
- Diagnoses: Schizoaffective Disorder, Unspecified Mood Disorder, Anxiety Disorder, Excoriation (skin picking), Post Traumatic Stress Disorder, Insufficient Sleep Disorder, Constipation, Unspecified Paraphilic Disorder

Review on 3/12/25 of Client #1's treatment plan revealed:
- "Highly sexualized behaviors (verbal comments, access inappropriate content on the internet and inappropriate physical and sexual contact with others) that require a very high level of monitoring"
- "Needed direct supervision when on the internet to prevent access to inappropriate content"
- "Needed to be supervised around younger children due to past attempts at inappropriate sexual conduct"

Review of Client #2's record on 3/12/25 revealed:
- Admission Date: 11/08/19
- Diagnoses: Autistic Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Moderate Intellectual Developmental Disorder, Anxiety Disorder, Chronic Cluster Headache, Restlessness and Agitation, and Jaw Pain

Review on 3/12/25 of Client #2's treatment plan revealed:

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V 290	Continued From page 16 - "If given the chance, I am going to run and try to elope. I am quick and can be gone in a minute." - "It is best to always have two staff near me, because of my size and my unawareness of personal space and boundaries I can be very intimidating to those that don't know me ..." Review on 3/12/25 of Client #2's behavioral treatment plan revealed: - Targeted behaviors: self-injurious behavior such as biting self and hitting or slapping head), disruptive behaviors running around the facility with high intensity and throwing objects, and elopement leaving the car or facility without consent - Strategies included: - Alarms on external doors and all windows in Client #1's bedroom - Two staff in the car Review on 3/12/25 of the facility's incident reports for the period of 1/1/25 to 3/12/25 revealed: - All incidents were Level I reports - The reports were for Client #2 - 1/5/25 at 4:45 pm, Client #2 "ran" outside the facility unclothed while AFL Provider #1 had turned to grab a towel while he showered. AFL Provider #1 "proceeded to quickly guide [Client #2] back into the house (facility) as it was cold outside." - 1/6/25 at 4:30 pm, Client #2 "walked" out the facility through the back door and "ran" to a neighbor's property with AFL Provider #2 having redirected him back to the facility. There was no documentation of where AFL Provider #2 was when this incident occurred - 1/7/25 at 6:30 pm, Client #2 "opened up the kitchen window and put half his body through the window" while AFL Provider #1 was going "back and forth" between the kitchen and Client #2's	V 290		

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V 290	Continued From page 17	V 290		

room. AFL Provider #1 redirected Client #2 to another activity (unspecified)
- 3/11/25 at 5:45 pm, Client #2 was in the living room with his toys when he "eloped while staff (AFL Provider #2) was using the bathroom." AFL Provider #2 redirected Client #2 back to the facility.

Observation on 3/11/25 between 4:00 pm- 5:00 pm revealed:
- AFL Provider #2 transported Client #1 and Client #2 in a car to the facility with no other staff present in the car
- Client #2 jumped out of the car and ran to the neighbor's property to the right side of the facility
- Client #2 slapped his head, pulled his pants down, refused to go inside
- AFL Provider #2 was outside the facility for approximately 10-15 minutes
- Client #1 went inside with no staff present

Interview with the Behavioral Specialist on 3/13/25 revealed:
- Made monthly visits to the facility
- "Typically saw" 1 staff member present in the facility during monthly visits

Interview with the Monitoring Specialist Local Management Enity-Managed Care Organization (LME-MCO) on 3/13/25 revealed:
- Made unannounced visits to the facility
- Last visit 1 staff present in the facility
- Client #2 can quickly go out the door

Interview with the Clinical Director on 3/12/25 revealed:
- AFL Provider #1 worked 4 days on and 3 days off
- AFL Provider #2 worked 3 days on and 4 days off

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V 290	Continued From page 18 - Both providers lived in the home Interview with the Qualified Professional revealed on 3/12/25 revealed: - Two staff were needed to transport Client #2 in the car - Concerned when AFL Provider #1 worked alone with Client #2 because of his size compared to the provider's size and her ability to control the situation - Client #1 had sexualized behaviors that needed to be monitored online and around children due to past abuse of a sibling Interview with the Licensee on 3/12/25 revealed: - Made monthly visits to the facility - AFL Provider #1 needed another staff when working because "she's older" - Client #1 had to be monitored "major thing is the sexual thing we have to make sure not inappropriate around kids and monitor him online" - No controls set up to limit access to online material for Client #1 - No knowledge 1 staff transported clients to the facility - "Should have taken two" but they don't every time"	V 290		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility	V 736		

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V 736	Continued From page 19 failed to be maintained in a safe, clean and attractive manner and kept free from offensive odor. The findings are: Observation on 3/11/25 between 4:00 pm-5:00 pm of the facility revealed: -A strong odor of urine permeated inside the facility. Observation on 3/12/25 between 3:16 pm to 3:47 pm of the facility revealed: -Client #1's left window had 3 cracks in the glass which ranged from approximately 2 inches to 5-6 inches in the bottom window corner. -A large plastered and peeled unpainted area on the living room wall at the back of the living room sofa extended from the wall light switch to the front door in length. A 4 x 4 square area on this wall about the middle way of the sofa had peeled plaster approximately 2-3 inches in length and exposed the plaster mesh. -A circular crack approximately 3 inches in diameter was in the kitchen wall next to the back door. -2 windows on the exterior of the facility had torn window screens. One window had the middle of the screen missing and the second window had at least 4-5 linear tears on the screen. -At least 3 broken lattice panels were laying on the ground under the back wood deck with 1 nail exposed at the end of one of the lattice panels. Interview on 3/11/25 with Client #1 revealed: -The cracks in his window glass were there when he was admitted to the facility in 11/2023. Interview on 3/11/25 with Alternative Family Living (AFL) Provider #2 revealed: -The odor of urine came from Client #2 having urinated on the living room chair.	V 736		

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V 736	Continued From page 20 Interview on 3/12/25 with the Residential Director revealed: -One of his duties as the Residential Director was to ensure the facility maintenance. Interview on 3/12/25 with the Qualified Professional revealed: -She had not noticed the cracks in Client #1's left window. -The cause of the urine odor came from Client #2 who was incontinent and had urinated on the living room floor. -She did not know how long the living room behind the sofa had been left plastered and unpainted. -She did not know what caused the living room wall behind the sofa to be plastered. -The crack on the kitchen wall may have happened from a chair having been backed up against the wall. -"There's not a regulation about window screens." -She acknowledged the broken lattice pieces needed to be picked up to prevent injury. -She would follow up with the Residential Director about having the facility walls repaired and repainted and any loose objects outside cleaned up. Interview on 3/14/25 with the Chief Executive Officer revealed: -No response to the needed repairs of the facility.	V 736		