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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-694	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME - APEX	109 EVENING STAR DRIVE APEX, NC 27502

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V 000	INITIAL COMMENTS A complaint & follow up survey was completed on April 25, 2025. The complaints were substantiated (Intakes #NC00226598 & #NC00229600). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105	V105 Effective 5/1/25 all employee files have been moved to the company office. In the absence of the administrator the QP is the authorized person overseeing operations of the agency. The QP has access to the office at all times. The files will remain in the company office at all times. Prior to the administrator's absence a meeting will occur between the QP and the administrator to discuss /ensure that all records, keys, files, etc.. will be available to the QP at all times during the administrator's absence.	

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

BA QP — 5/28/25

STATE FORM QE0O11 If continuation sheet 1 of 170

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their policy on delegating management authority for the operation of services. The findings are: Review on 3/27/25 of the facility's records revealed: - Operating Authority Policy: "...The Administrator is...responsible for allocating adequate personnel...to ensure that quality assurance activities can be accomplished as well as annual evaluation of the Quality Assurance Program...The Administrator (Registered (RN)/Administrator/Owner) will be responsible for the following:...Designate qualified employees to be the authorized representative in the administrator's absence...In the absence of the Home's (facility) Administrator, inquiries concerning residents (clients) care will be referred to the appropriate senior staff member available." Review on 3/24/25 of a text message sent from the Qualified Professional (QP) to the Division of Health Service Regulation (DHSR) Surveyor on 3/24/25 revealed: - "...[RN/Administrator/Owner] is away. She sent me what I requested from the employee files. I need to check when she will return. I don't have access to the actual files (staff personnel records)." Interview on 3/18/25 the QP reported: - The RN/Administrator/Owner was out of the country on a "girls trip" and was supposed to	V 105		

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V 108	Continued From page 5 .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 observation, record review and interview, the facility failed to ensure 1 of 2 audited paraprofessional staff (#2) had Cardiopulmonary Resuscitation (CPR) and First Aid (FA) training and failed to ensure 2 of 2 paraprofessional staff (#1, #2) and 2 of 3 audited former paraprofessional staff (FS #3, FS #4) had trainings to meet MH/DD/SA needs of the clients served. The findings are: Finding A: Review on 3/19/25 of staff #2's personnel record revealed: - Hired 9/21/24 - No documentation of a CPR/FA certificate Review on 3/20/25 of an email sent from the Qualified Professional (QP) to the Division of	V 108	V 108 Personnel Requirements Effective immediately after the exit (4/25/25) the facility contracted with a QP for the purpose of training, monitoring and supervision during this period following the assigned QP is restricted from providing training and oversight. The contracted QP began providing training to the onsite staff (on duty at that time) and provided training to the newly hired staff person for that home. The facility has developed a training protocol/procedure to be implemented for all newly hired and/or relief staff assigned to this home. Prior to the start of providing coverage for these residents the administrator will ensure that CPR/FA, EBPI, medication administration	

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V 108	Continued From page 6 Health Service Regulation Surveyor on 3/20/25 revealed: - "I decided to check my email for [staff #2]'s information. This is some information I sent you previously. I am trying to locate her...CPR first aid...I'm also checking my email for supervision, social pop (population), mental health and other trainings" Review on 3/27/25 of a text message sent from the QP to the Division of Health Service Regulation Surveyor on 3/27/25 revealed: - A picture of staff #2's CPR/FA certificate dated 3/26/25 Interview on 3/18/25 staff #2 reported: - Was a fill-in staff and worked alone in the facility - Worked for two weeks in October, November and December 2024 - Didn't know about the clients when she started working in the facility in October 2024 - Received CPR/FA training with previous employer, but she didn't have the training certificate - Knew the procedure for giving chest compressions and rescue breaths Finding B: Reviews on 3/13/25 and 4/25/25 of client #4's record revealed: - Admitted 9/13/24 and discharged 4/17/25 - Diagnoses of Altered Mental Status, Wernicke Encephalopathy, Alcohol Use Disorder and Vitamin D Deficiency - A treatment plan dated 10/9/24 revealed client #4 had suicidal ideations Review on 4/1/25 of staff #1's personnel record revealed:	V 108	training and any other trainings for identified medical diagnoses are trained prior to that staff being allowed to work alone. Additionally, the QP will complete the following trainings: Client Rights, Confidentiality, MH Diagnoses/SPMI, Special Populations, PCP Goals/Treatment Plans/Supervision Assessment and Needs, Preventing Abuse, Neglect & Exploitation, Substance Abuse Awareness, Education and Prevention (as needed and if/when this is applicable) & Suicide awareness and prevention, incident reporting protocols and documentation. Other trainings to be provided within the first 30 days of hire will include; incident reporting, problem solving and conflict resolution, Effective communication and listening skills, cultural competence and coping skills.	

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V 108	Continued From page 7 - Hired 1/24/25 - No documentation of substance abuse awareness and prevention training - No documentation of special populations training - No documentation of suicide awareness and prevention training - No documentation of treatment goal and implementation training Interviews on 3/12/25 and 3/14/25 staff #1 reported: - Started working in the facility as a live-in staff on 2/1/25 and she worked in the facility alone - Knew the facility served mental health clients - Knew about mental health from previous jobs, but she never worked in a group home - The RN/Administrator/Owner instructed her to stay with the clients, showed her how to administer the clients' medication and "made sure I knew how to talk to mental health patients (clients)" - Didn't know the clients' diagnoses, but she knew the clients' diagnoses were in their records - The Registered Nurse (RN)/Administrator/Owner "didn't tell me how everybody (clients) was or their issues (behaviors)" - Didn't know what a treatment plan was and no one trained her on the clients' treatment plans - Was trained in suicide awareness and prevention - Knew to look for signs of sadness or depression Interview on 3/20/25 staff #1 reported: - Was currently training on substance abuse awareness and prevention - Knew to look for slurred speech and the smell of alcohol for someone suspected of alcohol use	V 108	Additionally, when possible the newly hired staff will be assigned to another home to shadow that staff in order to have the opportunity to observe operations and expectations. Going forward the facility will not allow anyone to work alone with clients unless they have the necessary trainings. This is the responsibility of the administrator.	

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V 108	Continued From page 8 - Knew the client's information was in their records Interview on 4/11/25 staff #1 reported: - Started working in the facility on 2/1/25 - The RN/Administrator/Owner came to the facility "sometime that week" to train her - Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had	V 108		

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V 108	Continued From page 10 (2025)..." Review on 4/1/25 of FS #4's personnel record revealed: - Hired 5/1/24 - No documentation of substance abuse awareness and prevention training - No documentation of supervision of needs training - No documentation of special population training - No documentation of treatment goals and implementation training Interviews on 3/27/25 and 3/28/25 FS #4 reported: - Started working in the facility in 2024, but she hadn't worked in the facility since December 2024 - Knew client #4 had a history of alcoholism and suicidal ideation - Was trained on substance abuse awareness and prevention, client's supervision needs and suicide awareness and prevention - The QP trained her on the goals and strategies of all of the clients' treatment plans and the clients' behaviors - The QP was "very adamant about that (staff trainings)" - Knew the client's information was kept in their records and she gave the client's information to the police when they arrived at the facility Interview on 3/13/25 the Crisis Intervention Team with the local Police Department (PD) reported: - Concerned the staff weren't trained on the clients - "Workers (staff) don't know enough information about the clients" and the staff "don't know where the information is" - "Workers are not equipped to know where	V 108		

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V 108	Continued From page 13 - She gave staff #2 the CPR/FA instructor's number so she could schedule her training in October 2024, but she didn't follow up to see if staff #2 completed the training - Hadn't received any reports of the staff not knowing the clients' information when it's requested by the police - She instructed staff to contact her and she provided the Police Officers the client's information when they arrived at the facility Interview on 4/17/25 the RN/Administrator/Owner reported: - The QP was responsible for training staff on suicide awareness and prevention, supervision of needs, treatment goals and implementation and substance abuse awareness and prevention - The QP conducted the trainings and put the staffs' certificates in their personnel records - Was unaware some staff were not trained in special population, suicide awareness and prevention, supervision of needs, treatment goals and implementation and substance abuse awareness and prevention This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 108	V109 privileging/Training Professionals The information that is referenced in this report as not being available is readily available in the form of Medication Administration records and therefore medication records are available 100% of the time. These are the documents that staff use to document medication administration on a daily basis and in most cases several times per day. It appears that Apex Police Department's protocol for filing a missing person report differs from other jurisdictions. Typically when a report is made only one phone call to report the person missing is required. The facility administrator and QP understand that the policy is different for this department.	
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.	V 109		

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V 109	Continued From page 14 (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 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 review and interview, the facility failed to ensure 2 of 2 Qualified Professionals (QP and Registered Nurse	V 109	Going forward to ensure that the report has been made, the reporting facility administrator, QP or staff will now ensure that there is a report # provided by the police department to the facility. This will indicate that a report has been filed. Additionally, any allegations of abuse, neglect or exploitation will be reported within the required reporting time limits.	

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V 109	Continued From page 16 F. Cross reference: G.S. §131E-256 Health Care Personnel Registry (V132). Based on record review and interview, the facility failed to ensure an allegation of neglect was investigated and failed to report the allegation of neglect to the Health Care Personnel Registry (HCPR) within 5 days of being notified. G. Cross reference: 10A NCAC 27G .5603 Supervised Living for Adults with Mental Illness -Operations (V291). Based on observation, record review and interview, 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 audited clients (#4). H. Cross reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on observation, record reviews, and interviews, the facility failed to implement policies governing their response to incidents as required. I. Cross reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on observation, record reviews and interviews, the facility failed to ensure incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 and 24 hours as required. J. Cross reference: 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions (V500). Based on record review and interview, the facility failed to report all incidents of alleged neglect to the County Department of Social Services (DSS) for 5 of 5 clients (#1, #2, #3, #4, #5).	V 109	There is a statement in the report made by the officer that "it didn't appear that the staff or administrator cared that the client was missing" that was more opinionated than factual. The administrator initiated the report and the requested information would have been available in documentation that was present on the premises in the form of the medication administration records. A full time staff has been hired for that home and is scheduled to begin work during the 2nd week of May. She has had all the required trainings and knows what information is needed and where to locate information. The contracted QP will provide additional training	

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V 109	Continued From page 18 services notes as specified by [Government Agency] standards and any other funding service." Review on 4/1/25 of the RN/Administrator/Owner's personnel record revealed: - Hired 11/13/09 - A signed job description dated 12/10/18 revealed the following Administrator responsibilities: - "Maintains an open line of communication with all staff, residents and families." - "Provides clinical oversight for homes under his/her supervision." - "Schedules and participates in team meetings as needed with treatment..." - "Reports incidents as required by state guidelines." - "Provides clinical supervision to ensure acquisition, retention or improvement in skills related to activities of daily living and social and adaptive skills." - "Provides clinical supervision to ensure that habilitation, training and instruction are coupled with elements of support, supervision and engaging participation to reflect the natural flow of training, and other activities as they occur during the course of the person's day and that support and supervision of the person's activities to sustain skills gained is provided." - "Provides clinical supervision to ensure the interactions with the person are designed to achieve outcomes identified in the plan of care." - "Provides clinical supervision to ensure provision of treatment interventions to ensure that the resident acquires skills necessary to compensate for or remediate functional problems as outlined in the person-centered plan (treatment plan)."	V 109	Another concern is that the report mentions that the guardianship agency could not be reached. In the many years that we have dealt with that particular agency, never, ever was there a problem contacting the on-call person. Calls have been made to that provider at different hours of the day, including calls made to them after midnight and the calls have always been answered or returned immediately.	

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V 109	Continued From page 20 2/20/25 and he spoke with the RN/Administrator/Owner at the facility - He wrote the 2/20/25 police report, but he paraphrased the conversation he had with the RN/Administrator/Owner - Had to review his body camera footage to determine if the RN/Administrator/Owner used the word "regularly" when she spoke about client #4's previous elopements from the facility - Could tell "no one (staff #1 or RN/Administrator/Owner) was surprised she (client #4) was gone" - "It didn't seem like they (staff #1 or RN/Administrator/Owner) cared, but I can't say for sure" - Didn't know client #4 "was taking mind altering medicine" or client #4's diagnosis on 2/20/25 because the RN/Administrator/Owner didn't give him client #4's information - Attempted to call client #4's private agency guardian to get client #4's information, but client #4's guardian didn't answer - The RN/Administrator/Owner stated that she spoke to client #4's private agency guardian, but she still didn't provide him with client #4's information - "Didn't know [client #4]'s mental status...If I knew then [client #4] would have been put in the system (entered into the National Crime Information Center (NCIC) as a missing person) that night (2/20/25)" - Didn't know client #4 was taking "mind altering medicine" or her diagnoses until 2/24/25 when the RN/Administrator/Owner called and reported client #4 still missing - Client #4 was entered into the NCIC system as a missing person on 2/24/25 - Instructed the RN/Administrator/Owner to contact the police in 48 hours if client #4 was located or not	V 109		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-894	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME - APEX	109 EVENING STAR DRIVE APEX, NC 27502

(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 109	Continued From page 22 Interview on 4/25/25 the QP reported: - The RN/Administrator/Owner knew client #4's information - The RN/Administrator/Owner was at the facility on 2/20/25 and RN/Administrator/Owner had to give the police client #4's information Interview on 4/1/25 the RN/Administrator/Owner reported: - Staff #1 called her and said client #4 left the facility on 2/20/25 - She called 911 to the facility - She came to the facility to help search for client #4 - She spoke with the Police Officers, but she didn't tell the Police Officers client #4 left the facility "regularly" - Recalled telling the Police Officer that client #4 went missing, but "[staff #1] did mention she (client #4) left the house...1 or 2 times before" - Was unaware client #4 had previously eloped from the facility - She gave the Police Officers client #4's medication and diagnoses, but "the police said they don't feel she's (client #4) in immediate danger and they won't going to make a report unless she didn't return in 48 hours...If she comes back before 48 hours let them know" - "Thought" the police said to wait 72 hours before reporting client #4 missing and she "thought" the police were going to come back to the facility to see if client #4 had returned - "After a few days, I asked staff (staff #1) if the police showed up. When she said 'no,' I called the police" to report client #4 missing on 2/24/25 Interview on 4/25/25 the RN/Administrator/Owner reported: - The Police Officers from the PD were "lying" - She was at the facility on 2/20/25 and she	V 109		

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V 109	Continued From page 28 guardianship information when it was requested. The RN/Administrator/Owner was instructed to notify the police in 48 hours if client #4 returned to the facility or not, but the RN/Administrator/Owner waited over 24 hours past the instructed time limit to contact the police to say client #4 hadn't returned and client #4 was not entered into the NCIC as a missing person until 2/24/25. Client #4 was located by the police at a hotel in a neighboring city and returned to the facility on 2/26/25. Client #4 missed her medications from 2/20/25 to 2/26/25, but the RN/Administrator/Owner didn't notify client #4's physicians about the missed medications. Staff reported client #4's elopements and suspected alcohol use to the RN/Administrator/Owner, but the RN/Administrator/Owner did not implement any changes in the facility until 3/15/25 and did not notify client #4's physicians about her alcohol use. The RN/Administrator/Owner also did not notify client #1's physician after client #1 refused 44 doses of medication from 3/7/25 to 3/12/25. Client #4 was intoxicated on 3/13/25 and displayed aggressive behaviors towards client #1. Clients #1 and #4 engaged in a verbal altercation which led to a physical fight. The police were called to the facility and client #4 was voluntarily committed. Her blood alcohol level was .242% which was high enough to cause physical and mental impairments. Clients #1, #3 and #4 did not have approved unsupervised time in the facility. On 1/12/25, FS #3 left the clients alone in the facility for an hour and she was not present in the facility to deescalate an altercation between clients #1 and #4. Clients #1 and #4 got into a verbal altercation and client #4 called the police on client #1. The Police and Emergency Medical Service arrived at	V 109		

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V 112	Continued From page 30 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop and implement goals and strategies to meet the needs of 1 of 5 clients (#4). The findings are: Reviews on 3/13/25 and 4/25/25 of client #4's record revealed: - Admitted 9/13/24 and discharged 4/17/25 - Diagnoses of Altered Mental Status, Wernicke Encephalopathy, Alcohol Use Disorder and Vitamin D Deficiency - A treatment plan dated 10/9/24 was signed by the Qualified Professional after the following statement: "The following signature confirms the responsibility of the Qualified Professional/Licensed Professional (QP/LP) for the development of this PCP (Person Centered Plan). This signature indicates agreement with the services/supports to be provided." - The treatment plan contained the goals and strategies to decrease client #4's alcohol use, aggressive behaviors, suicidal ideations (SI), homicidal ideations (HI) and excessive use of emergency services: - Goal #1: - The goal listed the following strategies: - "[Client #4] will meet with professional supports regularly in order to facilitate honest discussion of needs and communicate progress... [Client #4] will participate in treatment as agreed and will receive recommendations from the team and act on those recommendations...[Client #4]	V 112	V112 Assessment/Treatment Plan Client #4 has been discharged as of 4/17/25. Client #1 is functioning at baseline. Staff, newly hired staff, temporarily assigned staff... have been or will be inserviced on reporting protocols. For any client related incident requiring treatment, necessitating attention by EMS, involving police, related to behaviors (including substance abuse, leaving without notification, fighting, arguing, threatening, etc..) should be reported to the QP. The training entails the reporting protocols. The QP will follow up as needed. Treatment plans address current needs of clients. They will be updated as necessary when a behavior has been determined to cause a detriment (or possible) to the health and/or safety of any resident or others in the residence or community. The	

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V 112	Continued From page 32 (Emergency Medical Services) in order to leave the facility when she is angry or wants to self medicate." - The goal listed the following strategies: - "[Client #4] will meet with professional supports regularly in order to facilitate honest discussion of needs and communicate progress. [Client #4] will talk with providers as needed when she feels an increase in her symptoms or is experiencing new symptoms. [Client #4] will be open to researching information on diagnoses, illnesses and medical conditions. She will participate in the treatment process and consciously exert effort to gain insight into her illnesses through discussion, research, evaluations, etc." - "Residential QP will provide the following interventions: Supportive counseling, identification of barriers to skill development, referral linkage and identification to resources that can assist Client including medication evaluation. QP will provide coordination and oversight of initial and ongoing assessment activities, ongoing development, implementation and monitoring of the PCP, assessing progress and needs, provide guidance to other Residential staff and professionals and consultation with other healthcare providers, facilitate planning meetings as well as frequently inform [client #4] and providers of services, needs and progress. QP will meet with client no less than monthly for general discussion of mental health needs and progress. QP will inquire about symptoms and work with client on developing strategies to manage symptoms." - "Residential staff will administer medications as prescribed by client's medical provider ...Staff will document all psychotic behaviors, behavioral outbursts, verbal aggression and noncompliance...Will alert	V 112	staff have been inserviced on treatment plans and understanding interventions. In the future the QP will determine whether a staff is able to retain the information. If it is determined that the staff person is not able to execute the goals and/or interventions as outlined in the treatment plan then it should be determined that the person is incapable of continuing employment and this will be communicated. Whenever it has been determined that the facility is unable to meet the needs of client for any reason the facility will first seek additional support from the mental health provider, the LME/MCO, guardian, family, etc..	

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V 112	Continued From page 34 interventions: Supportive counseling, identification of barriers to skill development, referral linkage and identification to resources that can assist Client including medication evaluation. QP will provide coordination and oversight of initial and ongoing assessment activities, ongoing development, implementation and monitoring of the PCP, assessing progress and needs, provide guidance to other Residential staff and professionals and consult with other healthcare providers, facility planning meetings as well as frequently inform [client #4] and providers of services, needs and progress." - "...Staff will document all behavioral outbursts, verbal aggression and noncompliance (making poor choices) ...Staff will provide necessary support to ...enroll in social or educational program. Provide prompting and encouragement to begin registration process. Staff will encourage [client #4] to make choices that provide 'happiness and calm' to her life ...Residential Support Staff will provide the following interventions: Will assist client in finding activities she enjoys. Staff will provide client with options to choose from as well as encourage, verbal prompting and redirection in assisting client in preparing her scheduled preferred activities. Staff will assist and encourage client to participate in activities during the course of the year. Staff will accompany client to activities and support her as needed. Staff will provide necessary support and encouragement as client begins the process of getting involved in vocational rehabilitation, volunteerism or pursuing education, improving social or independent living skills or perhaps she might want to focus on parenting skills training (given that she will soon be a grandmother)." - Goal 4: - "Improve Independent Living Skills. Limited	V 112	If the issue or behavior is not one that the facility administration is not longer able to provide a safe environment for any person at the resident then a notice of discharge will be issued, up to and including immediate discharge, if it has been determined that the behavior involves concern for life of others.	

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V 112	Continued From page 36 necessary items. She will complete housekeeping responsibilities with minimum prompting. She will be supervised at all times when beyond the mailbox at the group home. She will not be approved for unsupervised time in the community at this time." - "Residential QP will provide the following interventions: Supportive counseling, identification of barriers to skill development, referral linkage and identification to resources that can assist client. QP will provide coordination and oversight of initial and ongoing assessment activities, ongoing development, implementation and monitoring of the PCP, arranging services, assessing progress and needs, ensuring services are continuous and matched to level of need, provide guidance to other Residential staff and professionals and consultation with other healthcare providers, facilitate planning meetings as well as frequently inform [client #4] and providers of services, needs and progress." - A Crisis Prevention and Intervention plan included in the treatment plan revealed the following: - "Significant event(s) that may create increased stress and trigger the onset of a crisis...[Client #4] will demonstrate loud, threatening and offensive language. She is confrontation. Will should racial slurs in an effort to engage the person in an argument. Make false statements when she wants to avoid situations." - "Crisis prevention and early intervention strategies that were effective...Talk to her in a calm manner. Validate her thoughts or ideas if that's appropriate. Encourage involvement in activities. Encourage her to practice coping skills (deep breathing, talking). Monitor closely when she reports being depressed or seems to becomes more active. You don't have to agree with her but don't disagree when she is angry or	V 112		

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V 112	Continued From page 38 professionals and consultation with other healthcare providers informing them of client #4's needs and progress - Scheduled monthly meetings with the QP discussing her needs and progress - Client #4's increased symptoms of depression, suicidal ideation and threats of self-harm - Client #4's behavioral outbursts, verbal aggressions and noncompliance - Client #4's excessive use of emergency services - Strategies developed to manage symptoms - Staff encouraging client #4 to participate in making snacks, light meal preparation, preplanned activities or schedules and monthly budgeting - The treatment plan did not have goals or strategies to address client #4's elopement behavior Finding A: Examples of how the facility failed to implement client #4's treatment plan Observations between 11:29am and 3:00pm on 3/12/25 revealed: - Client #4 was observed either in her bedroom or outside smoking on the front porch - Client #4 wasn't engaged in any structured activities Interview on 3/12/25 client #4 reported: - Didn't do any educational, recreational or social activities - She didn't do anything but sit around in the facility - Most staff that worked in the facility didn't have a car to transport the clients anywhere, but staff #1 had a car and she would take her to the store	V 112		

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V 112	Continued From page 40 - She started becoming more organized by writing things down and researching activities to do on her cellphone - Liked to go to the local grocery store to purchase her favorite diet soda and snacks - Staff #2 was supportive and she spoke with staff #2 "several times a day" about chores, creating shopping lists and finding things to do - Didn't like going to the mall because she liked shopping online - Didn't want to participate in "geriatric programs" or attend day programs - Was interested in going bowling, to the movies, restaurants or attending parenting classes - Earned money by completing online surveys, but she didn't know how to manage her finances - "I would like to budget, but I don't" - Used her money to purchase cigarettes from the store - Used to volunteer, but she's "not really interested...I don't want to do it" - The "type of people volunteering is a mixture of people...people doing community service for probation or people who are doing it as a requirement" and she wanted to be careful with the type of people she was around - She later reported that she's "capable of volunteering," but she hadn't researched any vocational or volunteering opportunities - Used to volunteer at two well-known volunteer agencies and participated in sororities and junior leagues groups prior to living in the facility - "I would love to get a (part-time) job" because she wanted the "interaction with other human beings" - "I think it (employment) would be very beneficial ...I think I would be part of society...Feeling like I accomplished something	V 112		

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V 112	Continued From page 42 outbursts - Didn't write progress notes or document anything about services provided for client #4 - Didn't assist client #4 with monthly budgeting - Didn't preplan activities or play games with client #4 - Didn't have preplanned activities, but she and the clients had "dance parties" in the facility and client #4 participated sometimes Interview on 3/24/25 staff #2 reported: - The QP trained her on client #4's diagnosis and the cause of client #4's diagnosis and what she needed to do in the facility - The QP spoke to her about client #4's goals and encouraging client #4 to participate in activities and programs when she arrived on 3/15/25 - She tried to speak with client #4 about her goals, but "[client #4] didn't want to discuss the goals with me" - Haven't seen client #4's treatment plan or the goals and strategies in client #4's treatment plan - Didn't know what she was supposed to do for client #4's goals - Didn't know she was supposed to assist client #4 with budgeting her money - "I thought it was [RN/Administrator/Owner] or [QP] that did the budget" - Didn't know she was supposed encourage client #4 to prep meals, "but [client #4] will sometimes come down (downstairs) and ask if there is something she can help with (in the kitchen)...she usually has her own snacks" - Didn't know she was supposed to assist client #4 with educational, social or independent living skills - She spoke with client #4 about going out in the community, "but she (client #4) refuses" - "Even [client #4] didn't want to participate in	V 112		

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V 112	Continued From page 44 outbursts - Didn't document on any of client #4's goals Interview on 3/13/25 the Crisis Intervention Team with the local Police Department (PD) reported: - Worked with the PD to help reduce police response to mental health calls - Was called out to the facility weekly and some of the calls were from client #4 reporting that staff weren't administering her medication or not having food in the facility Interview on 3/26/25 the QP reported: - Was on medical leave from October 11, 2024 until the last week of January 2025 and the RN/Administrator/Owner assumed some of her duties while she was gone - Was still able to perform some QP duties by phone during her medical leave - Was "still trying to catch up from being out" - The RN/Administrator/Owner oversaw the operations at the facility - The RN/Administrator/Owner went to the facility "every two weeks" - "I thought to myself, she sure goes over there a lot. Especially after staff #1 started" - Was responsible for developing the clients' treatment plans and she developed client #4's treatment plan - Was responsible for training staff on the clients' treatment plans - "I don't read the entire plan to the staff, but I go over the clients' goals and highlighted points" in the treatment plans - Trained the staff on client #4's needs and client #4's "confusion due to her diagnosis" - "I don't know why staff say they don't know about [client #4's] treatment plan" - Staff were supposed to engage the clients in various activities and social groups	V 112		

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V 112	Continued From page 46 - Conducted monthly meetings with client #4 when she visited the facility in October 2024, January 2025 and February 2025 - Spoke with client #4 and "inquired about symptoms" she was experiencing, but client #4 didn't report any issues and said "she was doing good" - Didn't document the meetings with client #4 - Didn't meet with client #4 in November 2024 or December 2024 due to her being on medical leave and "[RN/Administrator/Owner] was taking over for me when I was out" - "[RN/Administrator/Owner] was out there (facility) frequently...[RN/Administrator/Owner] told me that she spoke with [client #4] about how things was going in the facility" - Client #4 didn't budget her money because "[client #4] doesn't share money information with staff...she's independent with her money" - She recently learned that client #4 was completing online surveys to earn income - She spoke with client #4 about vocational rehabilitation in January 2025 and client #4 said she didn't want to - Don't know if the RN/Administrator/Owner spoke with client #4 about vocational rehabilitation or volunteering - Was responsible for writing clients' progress notes, but didn't do them - Her job description required her to document progress notes for "clients that get enhanced services," but clients didn't receive "enhanced services" in the facility - The RN/Administrator/Owner hadn't spoken with her about her not writing progress notes - Used to write clients' progress notes, but she stopped because "no one ever asks for the progress notes or documentation" - Didn't have documentation for client #4's behavioral outbursts	V 112		

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V 112	Continued From page 48 documented - She previously spoke to the QP about writing progress notes, but "she (QP) struggling to catch up" with her work since she returned from medical leave Finding B: Examples of how the facility's failure to develop and implement to address client #4's excessive use of emergency services. Example 1: Review on 3/26/25 of a police report dated 11/17/24 revealed: - Client #4 called 911 and reported FS #4 refused to administer her medication unless she completed her chores and she threatened to attempt suicide. Client #4 also reported the staff would retaliate if they knew she called 911. Client #4 was involuntarily committed (IVC) Review on 4/10/25 of client #4's EMS report dated 11/18/24 revealed: - "The PT (patient) (client #4) C/O (complained of) of worries and believes she is been bullied by the group home staff. The PT reported her medicine is being withheld from her if fails to complete her chores. The PT believes if she goes back into the group home she will be hurt or killed by the staff. EMS notes the PT has erratic speech, along with repetitive and purposeless movements ..." Review on 3/14/25 of client #4's ED Provider Note dated 11/18/24 revealed: - "[Client #4]...resides in a group home presenting to emergency department for a group home altercation. Patient (client #4) noting her medications are currently being withheld from her unless she performs chores. She notes the staff member (former staff (FS) #4) and other group	V 112		

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V 112	Continued From page 50 Example 4: Review on 3/12/25 of a police report dated 1/14/25 at 3:47pm revealed: - "Erratic resident...caller (client #4) is a resident. Caller states she does not know where the caregiver (staff)...Caller in upstairs bedroom , Caller saying the residents name is [Client #1]... [Client #1] last known to be down stairs...caller says [client #1] is 'crazy'...Now caller states caregiver is there but does not come out of her room. Caregivers room is right by the door downstairs...no threats made, talked to roommates there nothing was heard, [client #1] and Ms. [client #4] separated..." Example 5: Review on 3/12/25 of a police report dated 1/14/25 at 7:01pm revealed: - "B/F (black female) (Former Staff #3) light skin- can hear her yelling...caller (client #4) states that caregive (staff) hasn't fed them in 3 days - female is arguing in the background...caller states the female said if she wanted food all she has to do was come down stairs and ask for it...wants OFC (officer) to look inside the refrigerator and see that's there is nothing to eat there...Female is in the background stating that caller is 'R******d'...states the worker (staff) is a monster and doesn't feed them. Caller states that she is concerned that she will get in trouble for calling the police...[RN/Administrator/Owner] has control of funds for the residence, buys the food once a month...[FS #3]...(Police Officers) spoke with caller and checked fridge, food is in there and in freezer..." Example 6: Review on 3/12/25 of a police report dated 1/15/25 revealed:	V 112		

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V 112	Continued From page 52 - Didn't have a suspicion of client #4 consuming alcohol until 11/17/24 - Client #4 became aggressive with her when she refused to give client #4 her medication outside of the scheduled time - Client #4 "threatened me and got up in my face, I reassured her that she had her meds, but she said 'you better give me my meds' and she called 911" - Client #4 kept saying "I'm supposed to give it (medication) to her four times a day" - The police arrived and "they had to say something about her (client #4) being aggressive" - The EMS came and advised that client #4's medication could "makes her breath smell like alcohol" Interview on 3/13/25 the QP reported: - Was unaware client #4 had made multiple calls to the police until last night - The officer that responded to the facility on 3/12/25 talked to client #4 about "being a nuisance with the repeated (911) calls" Interview on 3/26/25 the QP reported: - Was unaware of the 911 calls that were placed between October 2024 and January 2025 - Was unaware client #4 was hospitalized on 11/18/24 - Found out about client #4's hospitalization when the facility's pharmacy needed clarification about physician orders in January 2025 - The RN/Administrator/Owner "hadn't reported any problems" with any of the clients in the facility - There were "no major incidents in the home (facility) that I'm aware of until the (client #4) elopement (2/20/25)" Interviews on 4/1/25 and 4/2/25 the RN/Administrator/Owner reported:	V 112		

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V 112	Continued From page 54 know, I don't remember" - Was unaware of the 11/30/24 and 1/10/25 incidents - Didn't know client #4 was calling the police to the facility - Recalled the police contacting her on 1/14/25 about client #4's allegation of not having food in the facility - She spoke with FS #3 and FS #3 said "what they (clients) had for breakfast, lunch and dinner" - "She (client #4) chose not to eat because she had eaten earlier, and she wasn't hungry" - She spoke with client #4 and client #4 said "you can come and see," so she went to the facility and there was food in the house - Didn't have any issues with the facility not having enough food because she bought groceries every two weeks, so the facility didn't run out of food - The second 911 call on 1/14/25 incident was due to client #4 and client #1 arguing - Previously received calls "about [client #4] and [client #1] yelling back and forth" - She's "heard the way [client #4] was yelling," in February 2025, but she couldn't recall the exact date Finding C: Examples of how the facility's failed to develop goals and strategies to address client #4 eloping from the facility. Example 1: Review on 3/26/25 of a police report dated 11/8/24 revealed: - "Missing person // [client #4], W/F (white female)...L/S (last seen) 30 min (minutes) ago, cognitive impairments...caller has spoken to her (client #4) on the phone and she's upset...caller (staff #2) sees her walking up the street now, will stay with her until officer gets on scene...no	V 112		

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V 112	Continued From page 56 (5:00pm) and 1800 (6:00pm)...K-9 attempted to track but were met with negative results ..." Review on 3/12/25 of a police report dated 2/26/25 revealed: - "Female (client #4) was located with [unknown male]...located at [hotel] in [neighboring city]...Have been drunk for the past 4 days-large amount of alcohol covering the room...male picked her up from Evening Star on Thursday (2/20/25)..." Example 4: Review on 4/2/25 of a police report dated 3/15/25 revealed: - "[Client #4]. Walked out...to get alcohol, left approx (approximately) 20 minutes ago...Poss (possibly) near [local grocery store]...multi (multiple) call hx (history) in ref (reference) missing subj (client #4)...on foot...[local grocery store] cleared...lightly at loc (location) 20-30 mins ago to purchase alcohol, left on foot...subj should be walking back from [local grocery store] stated that she was 'going out to get a soda', adv units to check area enroute back from [local grocery store]...poss subj walking near daycare...bringing subj back to resd (residence)(facility)..." Example 5: Review on 4/10/25 of an Incident Response Improvement System dated 4/6/25 revealed: - "Date of Incident 4/3/25 ...At approximately 10:30 - 10:40 p.m. client (client #4) left the facility without notification. The administrator (RN/Administrator/Owner) was contacted and made the report to [local PD]...Client returned the next morning at approximately 11:30 a.m. and informed the staff and administrator that she had been out with her male friend..."	V 112		

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V 112	Continued From page 58 here (facility)" - Left the facility around 11pm on 2/20/25 and she returned at 5am on 2/21/25 - "Walked out the back door (exit door located in client #1 and #4 shared bedroom), walked to the store and he picked me up" - Staff #1 was in the facility when she left, but "I don't think she (staff #1) know I left out" - Her and the man went to a hotel in a neighboring city, and she consumed alcohol while she was gone Interview on 4/11/25 client #4 reported: - Met up with an "old boyfriend (4/3/25)," but she couldn't recall when - "I just wanted to hook up (have sex)" - Couldn't recall what time she left the facility - Recalled she "snuck away at night...after med (medication) pass" - Couldn't recall which door she used to leave the facility, but all the facility's exit doors had functioning alarms - Staff #1 was in the facility when she left, and she had to sneak around her - Walked to the local grocery store and the man picked her up - She and the man went to a hotel, but she couldn't recall where the hotel was located - She "probably" had wine while she was gone - The man dropped her back off at the local grocery store the next morning (4/4/25) and she walked back to facility - Believed she made it back to the facility before her morning medications were administered - Don't recall the RN/Administrator/Owner in the facility when she arrived the next morning Interview on 3/13/25 client #5 reported: - Client #4 "leaves without permission...leaves	V 112		

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V 112	Continued From page 60 came downstairs from their bedrooms "all the time" - Was working when client #4 left the facility on 2/20/25 - Recalled seeing client #4 on the balcony smoking that day, but she couldn't recall the time - She called client #4 for dinner around 4pm or 5pm and client #3 told her that client #4 didn't want to eat - Knew client #4 had a snack earlier and "she (client #4) doesn't like to eat a lot" - Went upstairs to client #3 and #4's shared bedroom to see why client #4 didn't want to eat and she realized client #4 wasn't there - She later reported that she didn't immediately go upstairs to client #3 and #4's shared bedroom to check on client #4 - "I thought she (client #4) was sleeping because the roommate (client #3) said she was sleep" - She called client #4 down for her 8pm medications and client #4 didn't come downstairs from her bedroom - She called the RN/Administrator/Owner when she realized that client #4 wasn't in the facility - The RN/Administrator/Owner called 911 and came to the facility to search for client #4 - Never saw alcohol in the facility - The "lady (FS #3) who left said she smelled alcohol" on client #4 before - "Smelled alcohol once when she (client #4) came back from leaving the facility...the police brought her back (to the facility)" Interview on 3/14/25 staff #1 reported: - Knew client #4 was leaving the facility to go to the store, but she never witnessed client #4 leave the facility - "The clients don't tell me when [client #4] leaves for the store"	V 112		

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V 112	Continued From page 62 she didn't know which client "trips the alarm" - Clients stopped smoking around 10pm every night - Believed client #4 left the facility prior to the last smoke break - Believed client #4 went out the facility's front door, but she didn't see client #4 leave Interview on 4/16/25 staff #1 reported: - She checked client #4 every 2 to 3 hours - "Most of the time they say downstairs or outside" - Didn't know about the hourly checks on client #4 between 8am and 9am Interview on 3/18/25 staff #2 reported: - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but she didn't arrive until 3/15/25 - Was informed about client #4 when she arrived to the facility on 3/15/25 - The RN/Administrator/Owner didn't inform her about client #4's increased behaviors when they spoke on 2/21/25 - "That's the first time I heard about [client #4] drinking and acting out" - Client #4 left the facility through the front door on 3/16/25 - "The alarm went off, so she (client #4) didn't go out the back (the exit door in client #3 and #4's shared bedroom)...I tried to stop her, and she said she was going to buy a beer" - She called the RN/Administrator/Owner and the RN/Administrator/Owner instructed her to call 911 - The local police came to the facility and client #4 was "disruptive with the police" Interview on 4/12/25 staff #2 reported: - Checked on client #4 all the time	V 112		

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V 112	Continued From page 64 January 2025 - Never worked in the facility prior to 1/22/25 - Hadn't seen alcohol or anyone intoxicated in the facility - No one eloped from the facility Interview on 3/17/25 client #4's private agency guardian reported: - Client #4 was "brilliant and college educated," but she had "alcohol induced dementia...Wernicke Korsakoff" - Client #4 used to "live independently" until she was hospitalized because she "couldn't even think for months" - Client #4 "sneaks alcohol" and she "doesn't know how to fix it" - Client #4 eloped from the facility and "went with a man" on 2/20/25 - "She (client #4) was returned by the time I was about to do a missing person's report" - Client #4 didn't sustain any injuries during the elopement on 2/20/25 - Was aware of the exit door in client #4's bedroom, but she wasn't concerned with her (client #4) eloping through the exit door because eloping wasn't a problem - "[Client #4] wasn't that type to leave out and purchase alcohol...Every time I talked to her she was doing good" Interview on 3/19/25 client #4's private agency guardian reported: - Client #4's alcohol use in the facility "just started around January (2025)" - FS #3 called her on 1/27/25 - FS #3 reported client #4 had been "walking off (from the facility)" and she found alcohol in client #4 and client #3's shared bedroom - FS #3 reported "it (client #4 eloping on 1/27/25) wasn't the first time" and client #4's "first	V 112		

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V 112	Continued From page 66 - Recalled instructing the staff to call 911, but she couldn't recall if the staff spoke about seeing client #4 walking down the street - Recalled on 11/11/24 client #4 "said she was taking a walk," but client #4 didn't have approved unsupervised time - Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month - "I don't know which staff was just letting her (client #4) leave the house" - Then later reported "staff was unaware [client #4] was leaving the house" - Didn't know client #4 was leaving the facility "like that" and "if I did, I told them (staff) to call the police" - "Every time the police came (to the facility) I told staff to call me so I can talk to the police" - "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" - She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" - She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" - "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" - On 2/20/25, staff #1 called her and reported client #4 missing - She went to the facility and drove around the area looking for client #4 - She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" - Recalled telling the police that client #4 eloped from the facility, but "[staff #1] did mention she (client #4) left out the house before...one or two times before"	V 112		

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V 112	Continued From page 68 client #4 being voluntarily committed. Observations between 11:29am and 3:00pm on 3/12/25 revealed: - Client #4 was sitting on her and client #3's shared bedroom floor scrubbing a brown stain with a brush - Client #4 was observed either in her bedroom or outside smoking on the front porch - Client #4 wasn't engaged in any structured activities - A small green carton located on the railing of the balcony Observation at 11:34am on 3/14/25 revealed: - A small green carton still on the railing of the balcony - Identified the small green carton located on the balcony railing as boxed wine Review on 3/13/25 of client #4's ED provider note dated 3/13/25 revealed: - "Patient (client #4) with a past medical history of alcoholism...Warnicke's encephalopathy presents escorted by [local town] to PD with concerns of altercation with group home staff...She (client #4) states that she is scared. This seems to be surrounding around alcohol abuse and her not receiving her medications...Will obtain screening blood work...Patient with alcohol level of 242. At times has become agitated with staff ...Mental health and wellbeing has evaluated the patient and also spoke with the...group home individual. States that patient has been drinking more becoming more agitated and irritable and causing more issues with staff. Today (3/13/25) had a physical altercation with another individual (client) with the state auditor (Division of Health Service Regulation (DHSR)) there...At this time we	V 112		

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V 112	Continued From page 70 because she was drunk" - "Last night (3/12/25)" client #4 was "drinking wine" and "[Client #4] got drunk" - Last night she woke up to client #4 cussing at her and calling her derogatory names - The RN/Administrator/Owner came to the facility that night to bring groceries and so she walked downstairs to the kitchen to help the RN/Administrator/Owner put the groceries up - Client #4 threw her bed linen and fan off of the balcony - There was a white blanket and white circular floor fan outside on the ground in the back yard - Client #4 broke her fan and she was upset that client #4 damaged her property - The "police came saying they had call from [client #4] about not having meds" - Client #4 "always say she suppose to get her meds four times a day, but that's false" - Last night the "[RN/Administrator/Owner] went up there (clients #3 and #4 shared bedroom) to look under the bed and she (client #4) pushed [RN/Administrator/Owner] and called her the N-word" - "She's (client #4) just wild" and "it's frustrating because she loves drinking wine" - "She (client #4) act like she want to fight but she don't fight me ...She act like she a thug and want to fight ...She's come close (fighting someone) but haven't followed through" - The RN/Administrator/Owner knew about client #4 drinking alcohol in the facility - FS #3 found bottles of alcohol behind client #4's bed in their shared bedroom a few months ago and reported it to the RN/Administrator/Owner - Witnessed FS #3 call the RN/Administrator/Owner and "asked her why she didn't tell her about [client #4] leaving to buy alcohol"	V 112		

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V 112	Continued From page 72 - Client #4 was "mostly' upstairs and staff #1 was "mostly" downstairs in the staff's bedroom - Later reported she felt safe when client #4 was intoxicated, but "she (client #4) just shouldn't do it (drink alcohol)" Interview and observation at 11:48am of client #4 on 3/13/24 revealed: - Client #4's hair was disheveled, her speech was slurred and she smelled of alcohol - Client #4's eyes were glossed over and her eyelids were half shut - Client #4 sat down and immediately started crying - She denied drinking alcohol and calling the police to the facility - Never called the police because she didn't have a reason to call them - Client #1 entered the dining room, apologized for interrupting the interview and client #4 smiled at her and said "oh, she's (client #1) fine" - Soon afterwards, the front door to the facility opened and client #4 yelled "get the f**k out" - The QP entered through the front door and when client #4 saw the QP she started apologizing - Then immediately, client #4 started yelling at the QP - The QP exited the dining room and client #4 stopped crying and continued with the interview - Client #4 then stated she would get in trouble for participating in the interview and refused to answer the questions asked - Client #4 started raising her voice while she expressed her fear of retaliation from staff for participating in the interview - Client #4 made threats and derogatory statements towards DHSR Surveyor - The DHSR Surveyor attempted to redirect client #4 away from the dining room table, but	V 112		

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V 112	Continued From page 74 - The QP stated she was going to the magistrate office to file an IVC for client #4 because she "never seen her (client #4) like this" - At 12:47pm, the QP instructed staff #1 to call 911 if anything happened and left the facility - At 12:58pm clients #1 and #4 were upstairs and they started yelling at each other - Client #4 yelled "I'll k**l you!" - Music began playing - Client #4 told client #1 to "shut the f**k up!," and the music stopped - Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication - Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs - Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again - Clients #1 and #4 were yelling at each other again - Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner - Client #4 made the following threats: - "I will f*****g hurt you!" - "You shut up or you will die and I f*****g mean that!" - "I will beat you to g*****n death!" - The music started playing again - The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually fighting" - Staff #1 ran back upstairs and client #4 yelled "she (client #1) hit me in the face"	V 112		

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V 112	Continued From page 76 - The clients went into their bedrooms and client #1 closed her bedroom door - She came back downstairs and then she heard "a boom" and the clients yelling - She went back upstairs and saw client #4 coming from her bedroom - Client #4 said client #1 kicked her in the lip and she saw a small cut on the top right corner of client #4's mouth - Client #4 went to the balcony outside of her and client #3's shared bedroom and called 911 - She was going to call 911, but client #4 called 911 faster than she could - A Police Officer approached and asked to speak with staff #1 about the incident Interview and observation at 1:46pm on 3/13/25 client #3 reported: - Client #3 was sitting in the foyer near the facility's front door - "[Client #1] and [Client #4] never got physical until today" - She felt safe because "I can handle myself, it's (client #4's intoxicated behavior) just frustrating" Interview and observation at 1:51pm on 3/13/25 the local Police Officer reported: - Could smell alcohol on client #4 - Saw a "light orange area" on client #4's face, but she wasn't sure if the discoloration was a bruise - The Police Officer placed her hand over the lower right side of her lip and chin area to show the area of the discoloration - She spoke with the RN/Administrator/Owner - Client #4 went to the local hospital for voluntary commitment - Didn't arrest client #4 or #1 for assault because she was unable to identify who initiated	V 112		

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V 112	Continued From page 78 suspected client #4 of drinking alcohol in the facility - Didn't know client #4 was walking to the local grocery store - Didn't recall FS #3 reporting client #4's alcohol use on 1/27/25 - Staff #1 "never reported" her suspicion of client #4's alcohol use - Staff hadn't reported client #4 was drinking alcohol daily or every other day - "Staff are supposed to tell us when clients are drinking alcohol" - "Normally they (staff) would tell [QP]" about level I incidents - "Staff know what [QP] handles...staff know to call [QP] when it's client behaviors" - The QP then informed her of the reported incidents - "I don't know why they (staff) would not say anything" about client #4's alcohol use - Recalled the 3/12/25 incident because she was at the facility - Recalled going upstairs to the clients' bedrooms to "say hi" - She heard a knock on the facility's front door and the police were at the door - Client #4 called 911 and alleged she "didn't get her medicine" - Client #4 became verbally aggressive and started "cussing at me...screaming in my face" - "She (client #4) got in my face, but I don't think she pushed me that night (3/12/25)" - She "looked in the room (client #1 and #4's shared bedroom) and saw empty bottles (alcohol)...about 3 bottles, located on a bag next to the (client #4's) bed" - Was on the phone with the QP and she told the QP what she found in client #3 and #4's shared bedroom - Didn't cross her mind that client #4's	V 112		

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V 113	Continued From page 81 disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a complete record for 5 of 5 clients (#1, #2, #3, #4, #5). The findings are: Review on 3/12/25 of client #1's record revealed: - Admitted 8/30/07 - No documentation of progress towards goal outcomes Review on 3/12/25 of client #2's record revealed: - Admitted 11/2/20 - No documentation of progress towards goal outcomes Review on 3/12/25 of client #3's record revealed: - No documentation of progress towards goal outcomes - No face sheet containing admission date or diagnoses Review on 3/21/25 of a text message sent to the Division of Health Service Regulation Surveyor from the Qualified Professional (QP) on 3/21/25 revealed: - Client #3 was admitted 5/24/23 Attempted review on 3/12/25 of client #4's record was unsuccessful because client #4's record was not in the facility. Observation at 11:55am on 3/13/25 revealed:	V 113	V113 Client Records The client records are to be maintained by the facility staff. The QP has instructed and provided training to the staff on how to maintain a record and what is to be included in that record. The newly hired staff will be starting during the 2nd week of May and has experience on how to maintain a client record. Additionally, staff are responsible for completing the face sheets and inserting them in the client records. The administrator and/or QP will check maintenance of the records during the quarterly QA reviews. QP will resume completing monthly progress notes to reflect any progress, lack of progress or concerns and inserting them in the records on a monthly basis.	

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V 113	Continued From page 83 Interview on 3/27/25 Former Staff (FS) #4 reported: - "Don't document anything" and didn't write progress notes - Didn't document on any of client #4's goals - Didn't document client #4's behavioral outbursts Interview on 3/28/25 FS #4 reported: - Was responsible for maintaining the clients' records by ensuring the client record had the client's face sheet and the clients' after-visit summaries from medical appointments Interview on 3/13/25 the QP reported: - Couldn't find client #4's record so she created a new one by printing off documents she had stored on her computer - Wasn't sure where client #4's record was - Client records were supposed to be kept locked in the facility's medicine closet Interview on 3/18/25 and 3/26/25 the QP reported: - Wasn't responsible for maintaining the clients' records - "I'm not doing anything clerical...I told [RN/Administrator/Owner] that is not my responsibility" - Didn't know where client #3 and #4's face sheets were - Staff were supposed to maintain the clients' records, but she and the RN/Administrator/Owner were responsible for ensuring staff maintained the client records by conducting quarterly record reviews - The last record review was completed in September 2024, and it was now time to do another review	V 113		

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V 113	Continued From page 85 - "A lot of them (clients) don't have face sheets" because "all of the information is on the FL2" - "We will have to get back to doing that (face sheets)" - She and the QP were responsible for completing record reviews - Checked the client records and looked over the clients' documentation for the last three months - The QP brought her documentation and filed it in the client records - She and the QP were supposed to review the clients' records on 10/30/24, but they were "interrupted" by client #1's behavior and they couldn't complete the review - Didn't know where client #4's original record was, but she recalled client #4's record in the facility during the annual survey in October 2024 - Staff were supposed to document the clients' behavioral outburst because the behavioral outbursts were level I incidents - Progress on clients' goals were supposed to be documented - Didn't have documentation for client #4's behavioral outbursts - Was unaware clients didn't have progress notes in their records - "Talk to [QP] about the progress notes" - The QP assessed the clients' goals every month, but she's "struggling to catch up" with her work since she returned from medical leave This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 113		

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V 118	Continued From page 87 This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MAR current for 5 of 5 clients (#1, #2, #3, #4, #5). The findings are: Finding A: Review on 3/12/25 of client #1's record revealed: - Admitted 8/30/07 - Diagnoses of Schizoaffective Disorder-Paranoid Bipolar Type and Gastroesophageal Reflux Disease - Physician orders dated for the following medications: - 3/20/24: - ClearLax Powder mix 17 grams (gm) in 4-8 ounces (oz) of liquid and drink as needed (PRN) (Constipation) - 12/8/24: - Amlodipine Besylate 10 milligrams (mg) take 1 tablet (tab) by mouth (PO) every day (Hypertension) - 12/19/24: - Oxybutynin 5mg take 1 tab PO twice a day (BID) (Bladder Control) - 1/16/25: - Melatonin 3mg take 1 tab PO at bedtime (Insomnia) - Divalproex Sodium (Sod) 500mg take 1 tab PO BID (Mood) - Benztropine Mesylate (Mes) 0.5mg take 1 tab PO BID (Mood) - Trazodone 100mg take 1 tab PO at bedtime PRN (Sleep) - 2/25/25: - Olanzapine 10mg dissolve 1 tab under tongue at bedtime (Schizophrenia) Review on 3/12/25 of client #1's January and	V 118	V 118 Medication Requirements The staff on duty at the time of the survey was retrained on medication administration and documentation as well as on necessary reporting and documentation protocols for missed meds by a contracted RN. The incoming staff has been trained on medication documentation and administration previously and has an understanding of requirements.	

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V 118	Continued From page 89 - Oxybutynin 2/28/25 (pm) - Benztropine Mes 2/28/25 (pm) - Divalproex Sod 2/28/25 (pm) Interview on 4/16/25 client #1 reported: - Was administered her medications - Her medications were always in the facility Finding B: Review on 3/12/25 of client #2's record revealed: - Admitted 11/2/20 - Diagnosis of Schizoaffective Disorder-Paranoid Type - Physician orders dated for the following medications: - 3/22/24: - Vitamin B12 1000 microgram (mcg) take 1 tab PO every day (Supplement) - Vitamin D3 1000 units (U) take 1 capsule (cap) PO every day (Supplement) - 7/1/24: - Atorvastatin 40mg take 1 tab PO at bedtime (Cholesterol) - 10/14/24: - Haldol 2mg take 1 tab PO at bedtime (Schizophrenia) - Risperidone .05 mg take 1 tab PO at bedtime (Schizophrenia) - 10/21/24: - ClearLax Powder mix 17gm in 4-8 oz of fluid and drink every day Review on 3/12/25 of client #2's January and February 2025 MARs revealed: - The January 2025 MAR revealed the following dates the medications were not documented as administered and the box for the staff's initials were crossed out with a diagonal line or covered with white out: - ClearLax Powder 1/1/25 and 1/2/25	V 118	The staff have been trained on ordering medications when the supply is down to 7 days. This has always been the protocol. The pharmacy delivers medications on a predetermined schedule/cycle. At times the medications have to be ordered from other manufacturers and may not be available at the time it is requested. Therefore, ordering the medications when the supply is within 7 days of depleting is the protocol. Medications are to be administered as ordered by a licensed provider and staff are expected to follow those orders. Documentation of those administrations are responsibility of the staff person on duty and will be reviewed by the administrator and/or QP on a quarterly basis during QA reviews. Documentation and ordering protocols will be retrained by the contracted RN as needed.	

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V 118	Continued From page 90 (whited out), 1/4/25, 1/10/25 (whited out), 1/13/25 (whited out), 1/15/25 (whited out)-1/16/25 and 1/19/25-1/20/25, 1/22/25-1/30/25 (crossed out) and 1/31/25 - Vitamin B12 1/24/25 and 1/25/25 (crossed out) - Vitamin D3 1/24/25 and 1/25/25 (crossed out) - Atorvastatin 1/23/25 and 1/24/25 (crossed out) - Haldol 1/23/25 and 1/24/25 (crossed out) - Risperidone 1/23/25 and 1/24/25 (crossed out) - The February 2025 MAR revealed the following medications were not documented as administered: - Atorvastatin 2/28/25 - Haldol 2/28/25 - Risperidone 2/28/25 Interviews on 3/12/25 and 4/16/25 with client #2 provided limited information because client #2's speech pattern was difficult to understand. Client #2 reported: - Wasn't left alone in the facility overnight - The RN/Administrator/Owner would come to the facility and administer medicine to help - Was administered her medicine - Hadn't missed getting her medications - Her medications were always in the facility Interview on 3/13/25 client #2 verified that she and the clients were left alone overnight. The interview was unsuccessful because client #2 was difficult to understand due to her speech pattern and lack of pronunciation of her words. Finding C: Interview on 3/17/25 client #3's Department of Social Services guardian revealed:	V 118		

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V 118	Continued From page 92 - Metformin 1/23/25 (pm) (crossed out), 1/24/25 (crossed out) and 1/25/25 (am)(crossed out) - Daily-Vite 1/24/25 and 1/25/25 (crossed out) - Vitamin B12 1/24/25 and 1/25/25 (crossed out) - Clozapine 1/24/25 and 1/25/25 (am) (crossed out), 1/10/25-1/31/25 (2pm) and 1/23/25 -1/24/25 (crossed out) - Sertraline 1/24/25 and 1/25/25 (crossed out) - Divalproex Sod 1/23/25 (pm) (crossed out), 1/24/25 (crossed out) and 1/25/25 (am) (crossed out) - Olanzapine 1/24/25 (crossed out) - Clonazepam 1/24/25 (crossed out) - The February 2025 MAR revealed the following medications were not documented as administered: - Metformin 2/28/25 - Olanzapine 2/28/25 - Clonazepam 2/28/25 Interview on 3/12/25 client #3 reported: - Was administered her medicine daily - Only missed her medicine the night of 1/23/25 - FS #5 left the clients in the facility overnight on 1/23/25 - Didn't know when FS #5 left the facility - Didn't get her evening medicine on 1/23/25 - Client #4 and #5 retrieved the key to the locked medicine closet from the staff's bedroom - "She (client #4) said she wasn't going to miss her meds (medicine)" - Clients #4 and #5 administered their own medicine on 1/23/25 - The RN/Administrator/Owner came to the facility around 9am or 10am the morning of	V 118		

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V 118	Continued From page 94 following dates the medications were not documented as administered and the box for the staff's initials were crossed out with a diagonal line or covered with white out: - Certavite-Antioxidant 1/23/25-1/25/25 (crossed out) - Gabapentin 1/22/25 (pm) (crossed out), 1/23/25-1/24/25 (crossed out) and 1/25/25 (am) (crossed out) - Sertraline 1/23/25-1/25/25 (crossed out) - Atorvastatin 1/23/25-1/25/25 (crossed out) and 1/31/25 - Montelukast Sod 1/22/25-1/24/25 (crossed out) - Vitamin B1 1/23/25-1/25/25 (crossed out), 1/26/25 and 1/27/25 (whited out), 1/28-1/31/25 (crossed out) - Folic Acid 1/1/25 and 1/2/25 (whited out) and 1/3/25-1/31/25 - The February 2025 MAR revealed the following medications were not documented as administered: - Montelukast Sod 2/28/25 - Gabapentin 2/28/25 - The March MAR revealed the following medication was initialed indicating the medication was administered on 4/15/25: - Gabapentin 8am, 2pm and 8pm Interview on 3/12/25 client #4 reported: - Didn't know if clients were left alone in the facility overnight - "Staff won't give me (administer) my anxiety medicine...supposed to get my anxiety medicine 4 times a day" - Was administered her medicine daily - "Never gone a night without staff giving me my medicine" Interview on 4/16/25 client #4 reported:	V 118		

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V 118	Continued From page 96 out) - Olanzapine 1/23/25 and 1/24/25 (crossed out) - Olanzapine 1/23/25 and 1/24/25 (crossed out) - The February 2025 MAR revealed the following medications were not documented as administered: - Docusate Sodium 2/28/25 - Trazodone 2/28/25 - Olanzapine 2/28/25 - Olanzapine 2/28/25 Interview on 3/12/25 client #5 reported: - Never administered her own medicine - Was administered her medicine daily - "Don't think that (clients left alone overnight) has happened" - She later reported the RN/Administrator/Owner came to the facility the morning of 1/24/25 and administered the clients' medications - There wasn't a staff in the facility when the RN/Administrator/Owner arrived on 1/24/25 - FS #5 left the clients alone in the facility overnight Interview on 3/13/25 client #5 reported: - FS #5 left the clients alone in the facility 1/23/25 - FS #5 didn't administer the medicine to the clients before she left - She missed her evening dose of medicine - "No one (clients) got meds that night (1/23/25)" - Didn't have a negative consequence from not receiving her medications - She contacted the RN/Administrator/Owner the morning of 1/24/25 - "She (RN/Administrator/Owner) asked if the	V 118		

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V 118	Continued From page 98 - The RN/Administrator/Owner corrected her documentation error, but she couldn't recall when - Administered the clients' medications on 2/28/25, but she forgot to sign the clients' MARs - FS #3 was at the facility when she arrived on 2/1/25, not the RN/Administrator/Owner Interview on 4/16/25 staff #1 reported: - Client #4 missed "one dose" of her Gabapentin on 4/15/25 because the medication wasn't in the facility - Was "waiting on the pharmacy" to deliver client #4's medication - She called the pharmacy for refills "last week," and she called the pharmacy on Thursday (4/10/25) Friday (4/11/25) and Monday (4/14/25) to check on the refill - The pharmacy was supposed to deliver client #4's medicine on 4/14/25, "but they didn't" - Instructed to contact the pharmacy a week prior to the clients' medications running out to have them refilled - She "accidentally signed" client #4's March MAR on 4/15/25 because she "forgot she (client #4) wasn't here (in the facility)" and was at the hospital - Knew she was supposed to sign the clients' MARs after she administered the clients' medications Interview on 3/19/25 and record review of clients #1, #2, #3, #4, & #5's January 2025 MARs with FS #5, FS #5 reported: - Was a fill-in staff and she filled in to work at the facility on 1/22/25 - Filled in to work at the facility on 1/22/25 - Was the first time she worked at the facility - Couldn't recall how long she worked, but she "just did it (worked) for a couple of days" - Her initials were written on the clients' MARs	V 118		

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	MHL092-894	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

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V 118	Continued From page 100 Interview on 4/16/25 the QP reported: - Client #4 didn't receive her morning dose of Gabapentin on 4/15/25 because the pharmacy was late delivering the medicine to the facility - Client #4 called 911 when she didn't receive her medication - Staff #1 "failed to tell me that [client #4] ran out of medicine" - The pharmacy delivered client #4's medication the evening of 4/15/25 - She contacted client #4's private agency guardian and they both agreed for client #4 to go to the hospital to receive her medication Interviews on 4/1/25 and 4/2/25 the RN/Administrator/Owner reported: - Staff were responsible for administering the clients' medications and documenting the clients' MARs - Was responsible for checking the clients' medications and MARs - She's been checking the clients' medications and MARs "every week since [staff #1] started working (1/24/25)" - Her checking the clients' medications and MARs "depends on who's working...some staff are good at not making errors...[staff #1] is still training and needs coaching" - Would also check the clients' medications and MARs "if someone complained about their medication" - Client #2 wasn't administered her Docusate Sodium because "she had loose stool" - Couldn't recall if she or staff contacted client #2's doctor about her having loose bowels - FS #3 put the dashes on the clients' MARs and "she wasn't supposed to" - "The only time they (clients) didn't have meds was the night of the 23rd (1/23/25)"	V 118		

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V 118	Continued From page 102 document ...just draw one line across" to document an error Interview on 4/17/25 the RN/Administrator/Owner reported: - The pharmacy didn't fill and deliver client #4's medication to the facility - Staff #1 contacted the pharmacy a week prior to client #4's medication running out - Staff were supposed to contact the pharmacy a week prior to their medications running out	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately report medication errors and refusals to the physician for 2 of 5 clients (#1, #4). The findings are: Finding A: Review on 3/12/25 of client #1's record revealed: - Admitted 8/30/07	V 123	V123 Medication Requirements Medication Training has been conducted and will be updated and retrained as needed. Any medication refusals will be reported to the administrator/RN and the QP immediately . The administrator will inform the prescriber (MD, PA, NP, etc..)	

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V 123	Continued From page 104 - Benztropine Mes 3/8/25-3/12/25 (am and pm) Interview on 3/12/25 client #1 reported: - Missed her medication "lately" - Didn't want to take her medicine today because she "don't need it" Interview on 4/11/25 the pharmacist reported: - Was unaware of client #1's medication refusals in March 2025 - Called the facility on 4/10/25 and the facility "verified that they failed to contact me regarding her med (medication) refusals" Interview on 4/11/25 client #1's former Primary Care Physician (PCP) assistant reported: - Was unaware of client #1's medication refusals in March 2025 - Client #1 "suffers from a chronic condition of hypertension" - Amlodipine treats client #1's high blood pressure (BP) - Was concerned with client #1 refusing the Amlodipine because of the risks of her BP increasing Interview on 4/11/25 client #1's guardian reported: - The RN/Administrator/Owner called her and informed her of client #1's medication refusals in March 2025 - Client #1 had a history of refusing medications Interview on 4/11/25 staff #1 reported: - Verified her initials on client #1's March 2025 MAR - She crossed out her initials on client #1's March MAR because she made an error - Accidentally signed client #1's MAR when client #1 refused her medications	V 123	cont'd after a client refuses or misses 3 administrations of medication . Instructions for when to report were part of the medication training. Additionally, a level 1 incident report will be completed by the staff on duty for up to 2 refusals. Once a client has refused medications three times then a level 2 incident report will be completed in IRIS and will include notification of the prescriber.	

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V 123	Continued From page 106 Interview on 3/12/25 client #4 reported: - On 2/20/25 she "took off with a man... " - Left that night and came back the next morning - Didn't take her medications with her when she left the facility on 2/20/25 - "I left out around 11pm (2/20/25) and came back at 5am (2/21/25)" Interview on 3/14/25 staff #1 reported: - Transported client #4 to her 2/28/25 medical appointment Interview on 3/17/25 a nurse at client #4's Primary Care Provider revealed: - Was unaware client #4 eloped and missed her medication from 2/20/25-2/25/25 Interviews on 3/19/25 and 3/25/25 client #4's pharmacist reported: - Was unaware client #4 missed her medication from 2/20/25-2/25/25 - Client #4 shouldn't experience any negative consequences from missing her medication for 5 days Interview on 3/18/25 the Qualified Professional (QP) reported: - Client #4 eloped on 2/20/25 - Client #4 "declined medical treatment" when she returned to the facility on 2/26/25 - The RN/Administrator/Owner was responsible for coordinating the clients' appointments, but she would have contacted client #4's physicians if she knew client #4 was consuming alcohol Interview on 4/11/25 the QP reported: - Was unaware of client #1's medication	V 123		

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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 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 ensure an allegation of neglect was investigated and failed to report the allegation of	V 132	V132 HCPR NotificationIt is the responsibility of the QP to investigate and report any and all allegations of abuse, neglect and exploitation. QP accepts full responsibility for the fact that the incidents mentioned in the SOD were not reported as required. This will not happen again. Staff have been inserviced again, on supervision requirements for the residents in this home. At this time there is one resident who is not approved for unsupervised time in the home. Current staff and the newly hired staff have been educated on the requirements for providing supervision. At not time will this client or any other client who is not approved for unsupervised time be left alone in the home without staff supervision.	

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V 132	Continued From page 110 she threatened to attempt suicide. Client #4 also reported the staff would retaliate if they knew she called 911. Client #4 was involuntarily committed (IVC) Review on 4/10/25 of client #4's Emergency Medical Services (EMS) report dated 11/18/24 revealed: - Client #4 reported to EMS she would be hurt or killed by the staff if she went back into the facility and wanted to be transported to the hospital for her safety. Review on 3/26/25 of a police report dated 11/30/24 revealed: - Client #4 called 911 because she and FS #4 had a "verbal argument" because FS #4 refused to administer her medications Review on 3/12/25 of a police report dated 1/10/25 revealed: - Client #4 called 911 and reported FS #3 hadn't fed the clients in 3 days and had threatened to withhold medication from her Review on 3/12/25 of a police report dated 1/12/25 revealed: - Clients #1, #3 and #4 weren't approved unsupervised time and FS #3 left them in the facility alone. Client #4 called 911 on client #1 and there were no staff in the facility when the police and EMS arrived. Client #1 was involuntarily committed (IVC). Review on 3/12/25 of a police report dated 1/14/25 revealed: - Client #4 called 911 and reported FS #3 hadn't fed the clients in 3 days and she was "concerned" FS #3 would retaliate for her calling 911	V 132		

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V 132	Continued From page 112 neglect to the HCPR - Knew she was supposed to report allegations of neglect to the HCPR - Was on medical leave from October 11, 2024 to around the last week of January 2025 - The RN/Administrator/Owner assumed some of her duties while she was on medical leave - Clients #1, #3 and #4 didn't have approved unsupervised time in the facility - Was made aware of FS #3 leaving the clients alone on 1/12/25 when the EMS contacted her on 1/12/25 - Knew the police arrived but she was unaware client #1 was escorted to the hospital by the EMS - Spoke with the RN/Administrator/Owner on 1/12/25 about the incident and she "gave it (level II incident) to [RN/Administrator/Owner] to handle" - Was unaware FS #3 left clients #1, #3 and #4 alone for at least an hour - Didn't believe FS #3 leaving clients #1, #3 and #4 alone was neglect because "[FS #3] was only gone for a few minutes ...but I can see that (FS #3 leaving clients alone for an hour) as neglect" - Was unaware of the 911 calls that were placed between October 2024 and January 2025 - Was unaware client #4 was hospitalized on 11/18/24 - Found out about client #4's hospitalization when the facility's pharmacy needed clarification about physician orders in January 2025 - The RN/Administrator "hadn't reported any problems" with any of the clients in the facility - There were "no major incidents in the home (facility) that I'm aware of until the (client #4's) elopement (2/20/25)" - FS #5 contacted her on 1/23/25 saying she had to leave the facility - She called the unverified fill-in staff and	V 132		

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