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| V 000 | INITIAL COMMENTS<br><br>An annual and complaint survey was completed on July 15, 2025. The complaint was substantiated (intake #NC00230919). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.<br><br>This facility is licensed for 6 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 1 former client. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility | V 105 | | |

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| V 105 | Continued From page 1<br>can provide services to address the individual's needs; and<br>(C) the disposition, including referrals and recommendations;<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; | V 105 | | |

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| V 105 | Continued From page 2 | V 105 | | |

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to implement their policy regarding discharge affecting one of one former client (FC #3). The findings are:

Review on 7/2/25 of FC #3's record revealed:
-Date of Admission: 1/24/22
-Diagnoses: Intermittent Explosive Disorder, Other Psychiatric Disorder not due to a Substance or Known Psychological Condition, Tourette Disorder, Attention Deficit-Hyperactivity Disorder (ADHD), Autism Disorder, Diabetes and Mild Intellectual Disability.
-Discharge Summary dated 6/30/25: FC #3's date of discharge was identified as 5/9/25.
-Discharge Summary dated 7/9/25: FC #3's date of discharge was identified as 7/2/25.
-There was no written notice of a discharge from the facility.

Review on 7/2/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:
-5/8/25-"[FC #3] came into the [facility], pushed [client #2], kicked the kitchen trash can and grabbed the trash can lid and threw it in the living room almost hitting yet another individual. [FC #3] said that he was going to kill everyone and then to kill
himself. Staff called 911 for assistance. When officer arrived, [FC #3] was calm and sitting down. Officer offered to follow [ Residential Manager (RM)] to [Emergency Room (ER)] where [FC #3] could be assessed. [FC #3] was

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| V 105 | Continued From page 3<br>assessed and admitted to Behavioral Health unit for medication assessment."<br><br>Review on 7/3/25 of the facility's policy on discharge revealed:<br>-"It is the policy of Monarch to establish discharge/transfer criteria and procedures pertinent to all programs, sites and services...A discharge is defined as a permanent movement of an individual to another facility/setting which operates independently from the current facility/setting or complete discharge from the agency...The agency must provide a reasonable time to prepare the individual and his/her guardian and parents for the change (except in emergencies). This can be done by involving these individuals in the planning, providing services to assist the individual in preparing for the change and involving these individuals in any decision about the change since this decision is generally part of a team process...For individuals with a Developmental Disability (DD) who receive residential supports, the agency will provide the individual/guardian with a 60 days notice of intent to discharge...The qualified professional and/or designee shall ensure that the Team is informed and involved in the discharge/transfer process for an individual...The qualified professional or designee shall provide written notice of a discharge /transfer following approval of the Person's team."<br><br>Interview on 7/3/25 with the RM revealed:<br>-FC #3 was discharged from the facility on 5/9/25 while he was still in the ER.<br>-The Residential Director (RD) and Residential Team Leader (RTL) #2 dealt with FC #3's discharge process.<br><br>Interview on 7/10/25 with the RTL #2 revealed: | V 105 | | |

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| V 105 | Continued From page 4<br>-"I think [FC #3] was discharged from the facility in May 2025, however I'm not sure of the specific date."<br>-She was not responsible for the discharge process with FC #3.<br>-She "heard a meeting needed to be held to discuss [FC #3's] discharge from the facility."<br>-She was not a part of the discharge plan meeting.<br>-She tried to call FC 3#'s grandmother/legal guardian in May 2025 to make her aware of the discharge from the facility.<br>-FC #3's grandmother/legal guardian never returned her phone call.<br>-She did not give a written discharge notice to the guardians.<br>-The RD was responsible for completing the written discharge notice.<br>-She confirmed the facility failed to follow the discharge policy.<br><br>Interview on 7/3/25 with the RD revealed:<br>-FC #3's discharge date was on 5/9/25 from the facility.<br>-The RTL #2 took care" of the discharge process with FC #3 because RTL #1 was in training.<br>-She did the discharge summary on 6/30/25.<br>-There was no written discharge notice sent to the guardian prior to FC #3's discharge on 5/9/25.<br>-"I just returned 2 weeks ago and I'm not sure why [RTL #2] did not send the guardian a written discharge notice."<br>-She was told the RM tried calling the grandmother/legal guardian a few times and the grandmother/legal guardian never returned their calls.<br>-"I would normally send out the discharge notice, however I was just returning from medical leave."<br>-She confirmed the facility failed to follow the discharge policy. | V 105 | | |

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| V 105 | Continued From page 5<br><br>This deficiency is cross referenced into 10A NCAC 27G .5603 OPERATIONS (V291) for a Type B rule violation. | V 105 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | V 112 | | |

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| V 112 | Continued From page 6<br><br>This Rule is not met as evidenced by:<br>Based on record review, observations, and interviews, the facility failed to develop and implement goals and strategies to address client behaviors and needs and failed to obtain a written consent by a responsible party for a client's treatment plan affecting one of one Former Client (FC #3). The findings are:<br><br>Review on 7/2/25 of FC #3's record revealed:<br>-Date of Admission: 1/24/22<br>-Diagnoses: Intermittent Explosive Disorder, Other Psychiatric Disorder not due to a Substance or Known Psychological Condition, Tourette Disorder, Attention Deficit-Hyperactivity Disorder (ADHD), Autism Disorder, Mild Intellectual Disability and Diabetes.<br>-Discharge Summary dated 6/30/25: FC #3's date of discharge was identified as 5/9/25.<br>-Discharge Summary dated 7/9/25: FC #3's date of discharge was identified as 7/2/25.<br>-Person Centered Plan (PCP) dated 4/11/25.<br>-There was no goal and strategies to address FC #3 eloping from the facility and stealing while in the community.<br>-PCP had no written consent or agreement by FC #3's responsible party.<br>-No assessment for unsupervised time in the facility or community.<br><br>Review on 7/2/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:<br>-3/22/25-"...Staff was passing medication to an individual. The shadowing staff was assisting another individual. Staff reported she did not hear [FC #3] in the family room. She locked the med (medication) room door and both staff called his | V 112 | | |

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| V 112 | Continued From page 7<br>name and searched the inside and outside of the facility. Staff called [Residential Manager (RM)] to report his absence and [RM] requested staff to go to the local convenience store that [FC #3] has gone to in the past. [FC #3] was not located and staff returned to the group home (facility) and called 911 and shortly after the call the police arrived with [FC #3]. [FC #3] was located close to [local store]. [FC #3] was found with stolen candy once searched by the officer. The assisting officer made contact with [local store] to inform them of the stolen goods. [Local store] stated they would not press charges but he is banned from the store." Staff called the police department at 7:45 am.<br>-3/20/25-"[FC #3] went to the bathroom to brush his teeth. After a few minutes staff called [FC #3's] name with no response then knocked on the bathroom door with no response, staff opened the door and he was not in the bathroom. Staff checked the house (facility), and he was not located and 911 was called for assistance. [Local police department] arrived with [FC #3] a few minutes later." Staff called the police department at 6:45 am.<br>-3/19/25-"...[FC #3] ran away from the group home (facility). He went down the street to the convenience store. While there, had had stolen 3-24 oz [soft drink]. [FC #3] then went into the bathroom and locked himself in. The clerk called [local police department] was contacted. [Local police department] officer talked with [FC #3] and explained to him that he could not come back to the store. No charges were filed, and I took [FC #3] back home (facility). [Local police department] reported a report would not be filed." Staff called the police department at 3:30 pm.<br>-9/18/24-" ...[FC #3] eloped from Mainstream Group Home by taking the alarms off his window in his bathroom waited on staff to do their | V 112 | | |

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| V 112 | Continued From page 8<br><br>15-minute round to check on him, he was halfway out of his window when staff came and flushed his toilet so staff would think he was using the restroom and went the rest of the way out of his window and ran. Staff realized that he had gotten out of the window within a few minutes and could not stop him and he ran away from the home. Staff called 911 and let them know. 911 found him at [name of local store] stealing soda and snacks, which he had at home. [Local police department] brought him home." Staff called the police department at 5:04 (am/pm not indicated).<br><br>Review on 7/3/25 of facility Level I incident reports revealed:<br>-2/2/25-"at 3am [FC #3] was checked on and found in his room. at 4am i heard a noise and entered another persons room to find [FC #3] in the other room. [FC #3] was found with items on him from outside the house. [FC #3] gave me the items and i asked him to go to bed because it was late. I spoke to the staff in the morning and called [RM] shortly after. I was informed to preformed bedchecks every 15min (minutes) during my shift."<br>-12/15/24-"I was in the med room administering 4pm meds about 3:45 pm and another staff was in the bathroom. I noticed [FC #3] walk by the med room door to his room and put his coat on. I seen him walk by the med room window as I had it open. Then I got up and went to ask him what he was doing, and [FC #3] was nowhere to be found ...As I went out the front door for a 3rd time, I seen [FC #3] walking back towards the home down the road and yelled for him to come back to the home (facility) instantly. He did turn around and make his way back home. As he was back in the yard, I asked him what were you doing and thinking running off like that? He stated, I was just going for a walk, I responded, | V 112 | | |

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| V 112 | Continued From page 9<br>well you know you are not allowed to leave this house (facility) without staff present with you, [FC #3] stated he was sorry, and he was just going for a walk ..."<br>-6/19/24-" ...[FC #3] snuck out of his room and tried to walk quickly to the convenience store a quarter of a mile down the street to purchase a soda and get back before staff noticed he had left. [FC #3] bought two sodas at the store and was leaving the store to walk back when another staff member off duty, staff saw him at 7:30 pm approximately a quarter mile from the group home (facility), and pulled over to pick him up. Staff stated he was scared when he knew he got caught and was in the car and told her he bought three sodas. Staff brought [FC #3] back to the group home (facility) to me and explained what happened and how she found him ..."<br><br>Review on 7/9/25 of the local county Emergency Services Call Detail Report from May 2024 to May 2025 revealed:<br>Facility staff called during the following dates to report FC #3 eloped from the facility<br>-3/28/25-10:33 pm<br>-3/20/25-6:41 (am/pm not indicated)<br>-2/10/25-6:57 (am/pm not indicated)<br>-2/3/25-2:45 (am/pm not indicated)<br>-1/11/25-5:58 pm<br>-9/18/24-5:04 (am/pm not indicated)<br>-9/16/24-4:34 (am/pm not indicated)<br><br>Observation on 7/9/25 at approximately 9:25 AM revealed:<br>-The distance from the facility to a local convenience store was 0.8 miles.<br>-There was a 35 miles per hour (mph) speed limit sign on the road between the facility and the convenience store.<br>-There was no sidewalk on either side of the road | V 112 | | |

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| V 112 | Continued From page 10<br>between the facility and the convenience store.<br><br>Observation on 7/15/25 at approximately 9:42 AM revealed:<br>-There were 2 street lights on the street where the facility was located.<br>-One of the street lights was at the corner of the driveway and next to the property, and the other was at the opposite corner of the facility's property.<br>-There was a street light pole and light at the back left corner of the property.<br>-There was a motion detector light on the rear of the facility.<br><br>Interview on 7/2/25 with staff #1 revealed:<br>-FC #3 eloped "20 times or more in the last 6 months."<br>-He stated that "we couldn't even provide services to other clients" due to FC #3 "trying to get out of windows" when they did not have eyes on FC #3.<br>-FC #3 "needed to be supervised 24/7."<br>-FC #3 disabled the alarms that were put on his windows.<br>-FC #3 "would sneak" into other clients' rooms to get out of their windows.<br>-"[FC #3] would open windows throughout the facility and break out the screens to get out of the facility."<br>-He called the police and reported every time FC #3 eloped.<br>-FC #3 went to a convenience store nearby and stole soda and candy.<br>-FC #3 walked down the road between the facility and the convenience store.<br><br>Interview on 7/2/25 with staff #2 revealed:<br>-FC #3 attempted to elope "whenever he could and staff had to have eyes on him constantly."<br>-"It was getting in the way" of providing services | V 112 | | |

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| V 112 | Continued From page 11<br>to the other clients because FC #3 had to have constant supervision.<br>-Staff often "couldn't even go to the bathroom or work in another room" with a client because FC #3 would try to elope from the facility.<br>-FC #3 "would sneak" into other clients' rooms to get out their window.<br>-FC #3 also tried to elope through the living room windows if he was not being watched.<br><br>Interviews on 7/2/25 and 7/3/25 with the RM revealed:<br>-FC #3 needed to be "constantly watched" by staff because he would try to elope.<br>-FC #3 eloped from the facility about 10 times within the last year.<br>-FC #3 disabled the alarms facility staff put on his windows.<br>-FC #3 also went into client #2's room and climbed out client #2's window to elope.<br>-FC #3 was banned from 3 local stores in the area because he would steal from those stores whenever he walked away from the facility.<br>-The police told her that FC #3 living on that street where the facility was located was a safety risk, because it was a busy street.<br>-FC #3 was on the list with the Local Management Entity/Managed Care Organization (LME/MCO) since 9/2024 but the facility was told they LME/MCO didn't know when assigning a Care Coordinator would happen.<br>-FC #3 did not have a PCP to address his elopement and stealing in the community because he was on a waiting list to be assigned a Care Coordinator.<br>-The grandmother/legal guardian had not been signing the plan or updates to FC #3's plan due to the issue of the facility staff not being able to get in touch with the grandmother/legal guardian.<br>-There was no response from the | V 112 | | |

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| V 112 | Continued From page 12 | V 112 | | |

grandmother/legal guardian, and the only way they got anything completed with the grandmother/legal guardian was the RTL went to the grandmother/legal guardian's home and presented paperwork to the grandmother/legal guardian in person.
-She confirmed FC #3 had no strategies to address walking away from the facility and stealing in the community.
-She confirmed the facility failed to have written consent or agreement by the client or responsible party.

Interviews on 7/10/25 and 7/15/25 with the Residential Director (RD) revealed:
-She was aware that FC #3 had a history of leaving the facility and stealing.
-They tried to find placement for FC #3, "however [FC #3] was not appropriate for any of those homes."
-They had alarms on the windows and doors and FC #3 removed the alarms.
-"[FC #3] would still sneak out the windows."
-She met with the Former Residential Team Leader (RTL) last year and they talked about adding a goal and strategies to FC #3's plan to address him leaving the facility and stealing.
-"I had not looked at [FC #3's] plan lately, I thought there was a goal to address those issues."
-She confirmed FC #3 had no strategies to address walking away from the facility and stealing in the community.

Review on 7/15/25 of a Plan of Protection written by the Vice President of Operations dated 7/15/25 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? A goal and strategies will be added to address

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| V 112 | Continued From page 13<br><br>behaviors. [Residential Team Leaders] will be retrained on Monarch's (Licensee) Policy of Person Centered Planning to ensure the goals and strategies address challenging behaviors that could potentially create health and safety issues. Describe your plans to make sure the above happens. [Program Director] will retrain [Residential Team Leaders] on Monarch's Policy of Person Centered Planning to ensure the goals and strategies address challenging behaviors that could potentially create health and safety issues. This retraining will also address meeting the treatment and primary services and support needs to ensure health and safety is the primary focus of the planning process with a target date of 8-6-25."<br><br>FC #3's diagnoses included: Intermittent Explosive Disorder, Other Psychiatric Disorder not due to a Substance or Known Psychological Condition, Tourette Disorder, ADHD, Autism Disorder, Diabetes and Mild Intellectual Disability. FC #3 eloped from the facility 12 times between June 2024 and March 2025. Staff called the police 7 times to report FC #3 walked away from the facility. FC #3 would sometimes leave the facility between 4:00 am and 6:45 am. The street where the facility was located had no shoulder and busy traffic. The distance between the facility and the local stores was about 0.8 miles. FC #3 stole items from some of the local stores whenever he walked away from the facility. FC #3 was banned from 3 stores in the area for stealing. The facility neglected to develop and implement a goal and strategies to address FC #3's behaviors of elopement from the facility and stealing in the community.<br><br>This deficiency constitutes a Type A1 rule violation for serious neglect and must be | V 112 | | |

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| V 112 | Continued From page 14<br>corrected within 23 days. | V 112 | | |
| V 291 | 27G .5603 Supervised Living - Operations<br><br>10A NCAC 27G .5603 OPERATIONS<br>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.<br>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.<br>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.<br>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.<br><br>This Rule is not met as evidenced by: | V 291 | | |

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| V 291 | Continued From page 15<br><br>Based on record review and interviews, the facility failed to ensure coordination was maintained between the facility operator and other qualified professionals who are responsible for treatment/habilitation affecting one of one former client (FC #3). The findings are:<br><br>Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review and interviews, the facility failed to implement their policy regarding discharge affecting one of one former client (FC #3).<br><br>Review on 7/7/25 of an Emergency Room (ER) report from the local hospital dated 6/30/25 revealed:<br>-FC #3 was seen in the ER on 5/8/25.<br>-"[FC #3] was brought into the ER by [Residential Manager (RM)] after [FC #3] had aggressive behavior towards [client #2]...[FC #3] is known for aggressive behavior, however staff has been very vigilant on this behavior..."<br>-FC #3 was released from the ER on 6/30/25.<br><br>Review on 7/14/25 of medical notes from the ER dated 6/7/25 revealed:<br>-FC #3 had 2 separate incidents at the ER.<br>-On 6/7/25-[FC #3] tried to close the curtain to keep the male nurse away from him, but the male nurse pulled back the curtain, and said we need to leave it open...When I asked [FC #3] if he was having any issues, as I was going to walk out the door, [FC #3] said yes and put his back against the wall, proceeded to drop his pants, fully exposing his groin, and asked me to just touch it..."<br>-On 5/16/25 "[FC #3] threatened to harm staff, loud/yelling, physical assault to another, pacing, hitting or throwing items...this nurse went into the room to reorient [FC #3]...[FC #3] took off his | V 291 | | |

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| V 291 | Continued From page 16 | V 291 | | |

glasses and started to get off the bed while punching his fists together. [FC #3] backed me into a room 14 onto the bed and started yelling, cussing and hitting me..."

Interview on 7/7/25 with the Case Manager Supervisor from the local hospital revealed:
-FC #3 came into the ER on 5/8/25.
-He had been discharged from the facility while at the ER.
-He was not able to return to the facility after he was stabilized in the ER.
-FC #3 was reportedly sent to the ER "because he had assaulted someone and couldn't return to the facility."
-FC #3 was in the ER for 53 days. He was never admitted to the hospital.
-She began leaving messages at the facility regarding picking up FC #3 from the ER on 5/15/25.
-She began contacting Legal Aid and other outside providers on 5/19/25, after "I left another message" at the facility, to help get services for FC #3.
-She spoke to RM on 5/20/25.
-She informed RM on 5/20/25 that FC #3 was ready to be discharged back to the facility but was told that FC #3 had already been discharged from the facility.
-The RM told her they would not pick FC #3 up.

Interview on 7/9/25 with Case Manager from the local hospital revealed:
-FC #3 was "psych (psychiatrically) cleared," cleared by "[the psychiatric evaluator]" to return to the facility on 5/14/25.
-"The [behavioral health hospital evaluator] stated on 5/14/25 that [FC #3] "would not benefit from...a psychiatric facility" and was "alright to return to the group home."

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| V 291 | Continued From page 17<br>-She was not sure which hospital staff contacted the group home facility but that this was done on 5/14/25.<br>-The notes indicated the facility staff reported that FC #3 assaulted another client and could not return to the group home.<br>-On 5/9/25 the RM stated that FC #3 was not able to return to the facility as he was aggressive to staff and the other residents were afraid of him.<br>-FC #3 was never admitted to the hospital and spent the time from 5/8/25 until his release on 6/30/25 in the ER.<br>-FC #3 was released from the ER 6/30/25 to "a group home."<br>-There was "nothing in the record" indicating contact with FC #3's guardian.<br>-She did not have email contact with the facility.<br><br>Interview on 7/11/25 with the Case Manager Supervisor from the local hospital revealed:<br>-FC #3 was in a room in the ER by himself with a door and "a sitter" (hospital staff) monitoring him.<br>-FC #3 had no television in the room.<br>-FC #3 was given coloring books and played cards with ER staff.<br>-FC #3's activities were "he ate breakfast, lunch, and dinner in his room ...was escorted to the shower with security," which she noted was hospital policy, and interacted with ER staff.<br>-FC #3 was monitored constantly by hospital security following the incident on 6/7/25.<br><br>Interview on 7/11/25 with local hospital medical records staff revealed:<br>-FC #3 assaulted ER staff 5/15/25 or 5/16/25.<br>-FC #3 exposed himself on 6/7/25 and displayed "sexual aggression."<br>-FC #3 was monitored by both a hospital sitter and hospital security after the incident on 6/7/25. | V 291 | | |

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| V 291 | Continued From page 18<br><br>Interview on 7/14/25 with local Police Department Receptionist revealed:<br>-FC #3 was arrested by a different county Sheriff's Department on 7/6/25, and has remained in the local county jail.<br>-This was due to a warrant FC #3 had related to charges he received after assaulting an individual on 5/15/25 and indecent exposure on 6/7/25 while in the local hospital ER.<br><br>Interview on 7/14/25 with local county Sheriff's Department officer revealed:<br>-FC #3 was in the local county jail being held without bond.<br>-This was due to charges related to an assault on another person while in local hospital as well as indecent exposure while in local hospital.<br><br>Interview on 7/2/25 with the RM revealed:<br>-FC #3 stayed in the local hospital ER from 5/8/25 until 6/30/25.<br>-FC #3 was never officially admitted to the hospital.<br>-There was a warrant out for FC #3's arrest for assaulting an individual at the hospital.<br>-It was reportedly a hospital worker, a "sitter" watching FC #3.<br>-She spoke with the Case Manager from the hospital initially but later spoke with the Case Manager Supervisor.<br>-She spoke with hospital personnel first on 5/19/25 at which time they asked her if it would be safe to send FC #3 back to the facility, "No, we can't keep him safe."<br>-She sent hospital personnel FC #3's guardianship papers by email on 5/19/25.<br>-"I didn't say we wouldn't take him back but that it wasn't safe to bring him back to the facility."<br>-She tried to get in touch with FC #3's grandmother/legal guardian. | V 291 | | |

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| V 291 | Continued From page 19<br>-She tried to call, text, email to inform the grandmother/legal guardian of the situation and that FC #3 was being released from the ER.<br><br>Interview on 7/15/25 with the RM revealed:<br>-She called FC #3's grandmother/legal guardian and aunt/legal guardian on 5/9/25 and left voicemail messages informing them of FC #3's transportation to the hospital and subsequent discharge from the facility. There was no response.<br>-Regarding documentation of these calls "We normally do case notes...I'm not sure if I documented the calls."<br>-FC #3's aunt/legal guardian called RM after the ER called the guardians to pick FC #3 up.<br>-She received this call from aunt/legal guardian on 5/20/25.<br>-Aunt/legal guardian asked the facility if they could take FC #3 back until another facility could be located for him.<br>-The aunt/legal guardian was told that "it's not safe."<br>-She told aunt/legal guardian that FC #3 was "supposed to be getting screened" while in the hospital.<br>-She gave aunt/legal guardian the name and phone number of the [Monarch] personnel who was to screen FC #3.<br>-Aunt/legal guardian never called back.<br><br>Interview on 7/2/25 with the Residential Team Leader (RTL) #1 revealed:<br>-She has been at the facility since 4/28/25.<br>-She was still in training when the incident on 5/8/25 with FC #3 occurred.<br>-She met FC #3 once during the time she was in training.<br>-FC #3's date of discharge was 6/30/25.<br>-She sent paperwork to the ER with information | V 291 | | |

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| V 291 | Continued From page 20<br>regarding FC #3 and his intake to another provider on that date.<br><br>Interview on 7/10/25 with the Residential Director revealed:<br>-"[The Vice President of Operations] admitted she messed up the discharge process with [FC #3]."<br>-FC #3 was discharged from the facility on 6/30/25.<br>-Facility staff were still in contact with the ER the entire time FC #3 was at the ER.<br><br>Review on 7/15/25 of the Plan of Protection dated 7/15/25 written by the Vice President of Operations revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care? [Residential Team Leaders] and [Residential Managers] under this [Program Director] will be retrained on Monarch's (Licensee) Coordination of Care policy to ensure management will provide Coordination of Care to all individuals supported by the programs where this process is needed or required. Describe your plans to make sure the above happens. [The Program Director] will retrain [Residential Team Leaders] and [Residential Managers] on Monarch's Coordination of Care Policy to ensure management will provide Coordination of Care to all individuals supported by the programs where the process is needed or required. Coordination of Care allows the individual to receive a level of care that is specific to that individual's needs. When indicated, Monarch will communicate and coordinate care with other professionals providing care to the individual. Monarch staff shall document coordination of care activities. Target date is 8-6-25."<br><br>FC #3's diagnoses included: Intermittent | V 291 | | |

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| V 291 | Continued From page 21<br><br>Explosive Disorder, Other Psychiatric Disorder not due to a Substance or Known Psychological Condition, Tourette Disorder, ADHD, Autism Disorder, Diabetes and Mild Intellectual Disability. FC #3 was transported to a local hospital on 5/8/25 due to assaulting a fellow resident of the facility. He was screened in the ER for an evaluation. FC #3 was discharged from the facility following this incident. Discharge dates for FC #3 from the facility were listed as 5/9/25 and 7/2/25. FC #3's grandmother/legal guardian was not contacted in writing by the facility to inform the guardian of FC #3's discharge from the facility. FC #3 was cleared and ready for release from the ER on 5/14/25. The facility was called by hospital staff to inform them of this on 5/14/25. The facility refused to allow FC #3 to come back to the facility. FC #3 remained in the local hospital ER for 53 days with limited activity or engagement. FC #3 acted out aggressively towards ER staff, which resulted in legal charges, and an arrest on 7/6/25. FC #3 was being held in a local county jail without bond and remained in jail. The facility did not assist in coordinating FC #3's transition from the local hospital ER to another provider for placement.<br><br>This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days. | V 291 | | |
| V 366 | 27G .0603 Incident Response Requirements<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(a) Category A and B providers shall develop and implement written policies governing their | V 366 | | |

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| V 366 | Continued From page 22<br>response to level I, II or III incidents. The policies shall require the provider to respond by:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.<br>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:<br>(1) immediately securing the client record by:<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal | V 366 | | |

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| V 366 | Continued From page 23<br>review team;<br>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:<br>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;<br>(B) gather other information needed;<br>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and<br>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; | V 366 | | |

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| MAINSTREAM | 933 EAST SALISBURY STREET ASHEBORO, NC 27203 |

| (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 366 | Continued From page 24<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to implement a policy governing their response to Level II incidents as required. The findings are:<br><br>Review on 7/2/25 of FC #3's record revealed:<br>-Date of Admission: 1/24/22<br>-Diagnoses: Intermittent Explosive Disorder, Other Psychiatric Disorder not due to a Substance or Known Psychological Condition, Tourette Disorder, Attention Deficit-Hyperactivity Disorder (ADHD), Autism Disorder, Diabetes and Mild Intellectual Disability.<br>-Discharge Summary dated 6/30/25: FC #3's date of discharge was identified as 5/9/25.<br>-Discharge Summary dated 7/9/25: FC #3's date of discharge was identified as 7/2/25.<br><br>Review on 7/9/25 of the local county Emergency Services Call Detail Report revealed:<br>-Facility staff called to report FC #3 eloped from the facility on 3/28/25, 2/10/25, 2/3/25, 1/11/25 | V 366 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL076-049 | A. BUILDING: _____ B. WING _____ | 07/15/2025 |

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|---|---|---|---|---|
| V 366 | Continued From page 25<br>and 9/16/24.<br><br>Review on 7/9/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:<br>-There were no level II incident reports for the above calls made by facility staff.<br>-There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures.<br><br>Interviews on 7/3/25 and 7/15/25 with the Residential Manager revealed:<br>-FC #3 eloped from the facility about 10 times within the last year.<br>-FC #3 also stole from convenient stores whenever he eloped from the facility.<br>-Staff were responsible for completing incident reports.<br>-"I thought staff were doing incident reports."<br>-She was responsible for ensuring the incident reports were completed by staff.<br>-She confirmed the facility failed to implement a policy governing their response to Level II incidents as required.<br><br>Interview on 7/15/25 with the Residential Director revealed:<br>-She thought staff were doing the incidents reports for FC #3 whenever he stole and/or eloped from the facility.<br>-She wasn't sure why there were no incident reports completed for FC #3.<br>-She confirmed the facility failed to implement a | V 366 | | |

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| V 366 | Continued From page 26<br>policy governing their response to Level II incidents as required. | V 366 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding.<br>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:<br>(1) the provider has reason to believe that information provided in the report may be | V 367 | | |

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| V 367 | Continued From page 27 | V 367 | | |

erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and

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| V 367 | Continued From page 28<br>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure an incident was reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:<br><br>Review on 7/2/25 of FC #3's record revealed:<br>-Date of Admission: 1/24/22<br>-Diagnoses: Intermittent Explosive Disorder, Other Psychiatric Disorder not due to a Substance or Known Psychological Condition, Tourette Disorder, Attention Deficit-Hyperactivity Disorder (ADHD), Autism Disorder, Diabetes and Mild Intellectual Disability.<br>-Discharge Summary dated 6/30/25: FC #3's date of discharge was identified as 5/9/25.<br>-Discharge Summary dated 7/9/25: FC #3's date of discharge was identified as 7/2/25.<br><br>Review on 7/9/25 of the local county Emergency Services Call Detail Report revealed:<br>-Facility staff called to report FC #3 eloped from the facility on 3/28/25, 2/10/25, 2/3/25, 1/11/25 and 9/16/24. | V 367 | | |

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|---|---|---|---|---|
| V 367 | Continued From page 29<br><br>Review on 7/9/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:<br>-There were no level II incident reports for the above calls made by facility staff.<br><br>Interview on 7/15/25 with the Residential Manager revealed:<br>-FC #3 eloped from the facility about 10 times within the last year.<br>-FC #3 also stole from convenient stores whenever he eloped from the facility.<br>-Staff were responsible for completing incident reports.<br>-"I thought staff were doing incident reports."<br>-"I can't say why there were no incident reports for some of those incidents with [FC #3].<br>-"Staff are typically in the habit of doing incident reports whenever [FC #3] eloped from the facility."<br>-She was responsible for ensuring the incident reports were completed by staff.<br>-She confirmed the facility failed to report the above incidents to LME/MCO within 72 hours.<br><br>Interview on 7/15/25 with the Residential Director revealed:<br>-She thought staff were doing the incidents reports for FC #3 whenever stole and/or he eloped from the facility.<br>-She wasn't sure why there were no incident reports completed for FC #3.<br>-She confirmed the facility failed to report the above incidents to LME/MCO within 72 hours. | V 367 | | |