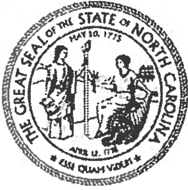

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 12, 2025

Moniker Brown
The Kids Workshop, Inc.
5901 Beaties Ford Road
Charlotte, NC 28216

Re: Complaint Survey completed August 28, 2025
Rockmoor Ridge Care Center
MHL # 8401 Rockmoor Ridge Road, Charlotte, NC 28215
E-mail Address: m.brown@tkwinc.org
Intake # NC00233171

Dear Ms. Brown:

Thank you for the cooperation and courtesy extended during the complaint survey completed August 28, 2025. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512).
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A1 violations must be ***corrected*** within 23 days from the exit date of the survey, which is September 20, 2025. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against The Kids Workshop, Inc. for each day the deficiency remains out of compliance.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 27, 2025.

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What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 336-247-1723

Sincerely,

Elizabeth Osborne
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
Kimberly Henderson Director, Mecklenburg County DSS
Michael Blake, Administrative Supervisor

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601498	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKMOOR RIDGE CARE CENTER	8401 ROCKMOOR RIDGE ROAD CHARLOTTE, NC 28215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 8/28/25. The complaint was substantiated (intake #NC00233171). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 1 current client.	V 000		
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	V 132	RECEIVED SEP 25 2025 DHSR-MH Licensure Sect	

Ursula Phillips - Clinical Director BA/DP 9-18-25

	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			

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
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ID Prefix Tag	Summary Statement of Deficiencies	ID Prefix Tag	Provider's Plan of Correction	Completion Date
V 132	Continued From page 1 providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) affecting 1 of 3 audited staff (Staff #1). The findings are: Review on 8/22/25 of Staff #1's personnel file revealed: -Hire date of 10/4/24. -Job title of Direct Care Service Provider. Review on 8/26/25 and 8/27/25 of the North Carolina Incident Response Improvement System (IRIS) from 8/1/25 to 8/27/25 revealed: -No documentation of a report to the HCPR for the allegation of neglect by Staff #1 related to the incident on 8/19/25 resulting in Client #1 burning his feet. Review on 8/27/25 of the facility's internal investigation report written by the Clinical Director revealed: -"[Clinical Director] conducted this investigation on 8-20-25 due to [Client #1] being burned. -The incident occurred on 8-19-25 with [Client #1] and [Staff #1] (staff) when [Staff #1] brought [Client #1] back to the AFL home (facility) to give him a bath. The bath was needed due to [Client #1] using the bathroom on himself while at the park. Apparently at 1pm [Staff #1] placed [Client	V 132	The Kids Workshop will ensure that the Health Care Personnel Registry (HCPR) will be done each time there is an allegation. The Kids Workshop will also ensure that the Internal Investigation done will be completed and uploaded in the IRIS report within 5 days of any notification where there is an allegation against staff.	10-1-25

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V 132	Continued From page 2 #1] in the bathroom to wait for him there while he went outside of the bathroom to gather a towel, a wash cloth, and soap. While gathering these supplies (not even a few feet from the bathroom) [Client #1] undressed completely without direction from [Staff #1], sat in the tub, and started running water in the bathtub. [Staff #1] immediately ran to the bathroom to see that [Client #1] was sitting in the tub naked with his legs drawn towards his chest in the tub with hot water running. It was apparent that the water was scolding hot; and [Staff #1] removed [Client #1] from the tub (burning himself). [Staff #1] said he saw that [Client #1's] legs were red and begun to blister. [Staff #1] panicked and called the other staff (#3) and the AFL [Staff #2] to let them know what had occurred and they both told [Staff #1] that he will need to take [Client #1] to the emergency room immediately. [Staff #3] came to assist [Staff #1] to get [Client #1] dressed which took time considering the burns and him needing to have a diaper on. [Staff #1] dressed [Client #1]'s feet with bandages and tape and picked him up to place him in the car and drove to [local] hospital. -In conclusion, [Staff #1] was placed on administrative leave (8/20/25) and will also be placed on the Healthcare Registry. This incident was the result of negligence on [Staff #1] part because he should not have left [Client #1] in the bathroom unattended to go and gather items." -There was no documentation that a report was made to the HCPR. Interview on 8/26/25 and 8/27/25 with the Clinical Director revealed: -Learned on 8/20/25 of the incident that occurred on 8/19/25 resulting in Client #1 being burned and was in the process of conducting an investigation. -Was responsible for reporting staff for allegations of abuse, neglect, and exploitation to	V 132		

(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 132	Continued From page 3 the HCPR. -Had not reported to the HCPR. "We are up in the air. I haven't concluded (the investigation)." Interview on 8/26/25 with the Licensee revealed: -"We decided that he (Staff #1) cannot work at that home (facility) anymore. We are going to check with Health Registry (HCPR). I think we are going to let him go." -Did not know if the Clinical Director had "finished" the investigation and reported to the HCPR.	V 132		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and	V 500		

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
	MHL0601498	A. BUILDING: ______ B. WING ______	C **08/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKMOOR RIDGE CARE CENTER	**8401 ROCKMOOR RIDGE ROAD** **CHARLOTTE, NC 28215**

(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 500	Continued From page 4 (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 500	The Department of Social Services (DSS) was involved as soon as the individual went to the hospital. The plan of correction going forward is to contact DSS immediately when there is an allegation towards staff. The IRIS report will reveal the date of contact to DSS and the name of the DSS professional whom information was given to.	10-1-25

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V 500	Continued From page 5 facility failed to ensure all instances of alleged or suspected abuse, neglect or exploitation were reported to the County Department of Social Services (DSS). The findings are: Review on 8/26/25 and 8/27/25 of the North Carolina Incident Response Improvement System (IRIS) from 8/1/25 to 8/27/25 revealed: -No documentation of a report to the DSS for the allegation of neglect by Staff #1 related to the incident on 8/19/25 resulting in Client #1 burning his feet. Interview on 8/26/25 and 8/27/25 with the Clinical Director revealed: -Learned on 8/20/25 of the incident that occurred on 8/19/25 resulting in Client #1 being burned and was in the process of conducting an investigation. -Was responsible for reporting staff for allegations of abuse, neglect, and exploitation to the DSS. -Did not report the allegation to DSS. Interview on 8/28/25 with the Licensee revealed: -Did not report the allegation to DSS. -"When I got the call (8/20/25 reporting the incident) they (DSS) were already involved."	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 6 purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		
	This Rule is not met as evidenced by: Based on record review, interview and observation 1 of 3 staff (#1) neglected and failed to protect 1 of 2 clients (#1) from harm. The findings are: Review on 8/22/25 of Client #1's record revealed: -Admission date of 3/1/22. -Diagnoses of Unspecified Convulsions; Autistic Disorder; Unspecified Mood Disorder; Conduct Disorder, Unspecified; Cerebral Palsy, Unspecified; Severe Intellectual Developmental Disability. -Individualized Service Plan dated 5/1/25: "He (Client #1) must be monitored closely due to lack of awareness and no fear of danger...communicates using gestures" -Crisis plan dated 5/1/25: "[Client #1] requires full physical assistance with regulating water temperature because [Client #1] does not know how to regulate water temperature and could		All staff of The Kids Workshop will continue to be trained on Abuse, Neglect, or Exploitation and what constitutes this according to 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION. This will continue to be reviewed with staff annually. Any staff we find in violation of this will be terminated and placed on the Healtcare Registry.	10-1-25

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKMOOR RIDGE CARE CENTER	8401 ROCKMOOR RIDGE ROAD CHARLOTTE, NC 28215

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V 512	Continued From page 7 easily burn himself ...[Client #1] should be closely monitored at all times to ensure that he makes safe choices when at home." -Behavior Support Plan dated 4/2/25: "He (Client #1) also requires 24-hour supports of supervision in order to maintain his health, safety and welfare and to assist him in making healthy judgements, [Client #1] has limited safety skills and limited understanding of potential environmental or architectural hazards in all areas." Review on 8/22/25 of Staff #1's personnel file revealed: -Hire date of 10/4/24. -Job Title of Direct Care Service Provider. -Client Specific Training for Client #1 signed by Staff #1 on 10/22/24: "Hands on assistance if required to complete daily living skills." Review on 8/22/25 of the facility's internal incident reporting form signed by Staff #1 on 8/19/25 revealed: -"Around 1pm (8/19/25) after leaving the park to come home (facility) and shower after an incident (toileting accident) [Client #1] sat in the tub and turned the water on without permission or supervision. I had just stepped out to gather his clothes, towel, and soap upon returning I could hear the water running I rushed to the bathroom to find [Client #1] just sitting in a partially filled bath of extremely hot water. Noticing the steam from the water and the direction of the shower dial I knew it was way too hot so I quickly shut it off and went to drain the water burning myself in the process." -"I took [Client #1] to the hospital immediately after trying to stabilize his feet and wrapping them to prevent dirt getting inside." -"I accept full responsibility for this (Client #1's burns) ...If I had just waited until I was prepared	V 512		

PRINTED: 09/10/2025
FORM APPROVED

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
	MHL0601498	A. BUILDING: ______ B. WING ______	C 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKMOOR RIDGE CARE CENTER	8401 ROCKMOOR RIDGE ROAD CHARLOTTE, NC 28215

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V 512	Continued From page 8 this could have been avoided." Review on 8/26/25 and 8/27/25 of the North Carolina Incident Response Improvement System (IRIS) from 8/1/25 to 8/27/25 revealed: -Date of incident: 8/19/25. -"[Client #1] was taken to his AFL (Alternative Family Living) home (facility) by [Staff #1] (Day Support worker) (facility's Direct Care Service Provider) due to him soiling his pants. [Staff #1] stated that as he obtained a towel and wash cloth for [Client #1] he immediately heard the water running in the bathtub. [Staff #1] went into the bathroom where he found [Client #1] naked in the bathtub (legs drawn towards his chest) running hot water. [Staff #1] removed [Client #1] from the bathtub and saw that his legs were red and his feet were blistered all from the hot water. [Staff #1] called the AFL (Alternative Family Living) (Staff #2), and the QP (Qualified Professional) to let them both know what happened and proceeded to take [Client #1] to the emergency room for his wounds." Review on 8/27/25 of the facility's internal investigation report written by the Clinical Director revealed: -"[Clinical Director] conducted this investigation on 8-20-25 due to [Client #1] being burned. -The incident occurred on 8-19-25 with [Client #1] and [Staff #1] when [Staff #1] brought [Client #1] back to the AFL home (facility) to give him a bath. The bath was needed due to [Client #1] using the bathroom on himself while at the park. Apparently at 1pm [Staff #1] placed [Client #1] in the bathroom to wait for him there while he went outside of the bathroom to gather a towel, a wash cloth, and soap. While gathering these supplies (not even a few feet from the	V 512		

	bathroom) [Client #1] undressed completely without direction from			

V 512	Continued From page 9 [Staff #1], sat in the tub, and started running water in the bathtub. [Staff #1] immediately ran to the bathroom to see that [Client #1] was sitting in the tub naked with his legs drawn towards his chest in the tub with hot water running. It was apparent that the water was scolding hot; and [Staff #1] removed [Client #1] from the tub (burning himself). [Staff #1] said he saw that [Client #1] legs were red and begun to blister. [Staff #1] panicked and called the other staff (#3) and the AFL [Staff #2] to let them know what had occurred and they both told [Staff #1] that he will need to take [Client #1] to the emergency room immediately. [Staff #3] came to assist [Staff #1] to get [Client #1] dressed which took time considering the burns and him needing to have a diaper on. [Staff #1] dressed [Client #1]'s feet with bandages and tape and picked him up to place him in the car and drove to [local] hospital. -In conclusion, [Staff #1] was placed on administrative leave (8/20/25) and will also be placed on the Healthcare Registry. This incident was the result of negligence on [Staff #1] part because he should not have left [Client #1] in the bathroom unattended to go and gather items. The water temperature was the responsibility of the AFL (Staff #2) because the temperature was too high at the time of the bath." Review on 8/22/25 of Client #1's hospital records from 8/19/25 to 8/21/25 revealed: -"Chief Complaint: Foot Burn (Pt (patient) BIB (brought in by) caregiver (Staff #1) after pt snuck into shower and turned the water up too hot and has burns to tops of bilateral feet, blistering) -Diagnosis: Burn any degree involving less than 10 percent of body surface (primary); burn by hot liquid. -Bilateral feet with circumferential superficial thickness burns to the dorsum of the feet (see	V 512		

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V 512	Continued From page 10 pictures). There are also small scattered blisters to the toes and there is also a blister to the left heel. -Total of about 9% body surface (was burned). -APS (Adult Protective Services) case to be filed ...due to severity of burns and unclear mechanism patient with this level of intellectual disability and motor delay." Review on 8/22/25 of the pictures of Client #1's feet taken by the hospital staff revealed: -Client #1's right foot was burned with peeled skin from his ankle, across the top of his foot, covering his last 3 toes and the majority of the knuckle of his big toe almost to the toenail. -Client #1's left foot was burned and blistered across the top of his foot in an area about the size of a deck of cards with a quarter sized blister above this area and small round blisters ranging from dime-sized to pinpoint-sized on his toes. -Client #1 had a thumbnail size blister and two smaller blisters on his left heel. Observation on 8/21/25 at approximately 12:30pm in the downstairs bathroom of the facility revealed: -Water temperature in the tub and sink was 118 degrees Fahrenheit. Attempted interview on 8/21/25 with Client #1 was unsuccessful due to him answering all questions with "yes." Interview on 8/26/25 with Staff #1 revealed: -Took Client #1 into the bathroom for a bath after a toileting accident on 8/19/25. -Client #1 got undressed. -Left the bathroom for "3 to 4 minutes" to get soap, clothes and a towel. -"When I had everything together, I heard the	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601498	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 08/28/2025

NAME OF PROVIDER OR SUPPLIER: **ROCKMOOR RIDGE CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **8401 ROCKMOOR RIDGE ROAD CHARLOTTE, NC 28215**

(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 512	Continued From page 11 water running. I dropped everything and rushed to the bathroom." -Client #1 was sitting in ankle deep water in the tub with the water running. -"I could see the steam and the dial was on hot." -Staff #1 turned off the water and drained the tub. -Client #1 was "sitting on his behind with his knees in the air. His feet were under the spout." -"He (Client #1) was not showing any signs of pain ...just sitting there." -"There was redness on his legs toward his butt." -"His (Client #1) feet were blistered." -"The burns were on the tops of his (Client #1) feet where they were directly under the water." -Staff #1 phoned Staff #3 for assistance. -Staff #1 was wrapping Client #1's feet when Staff #3 arrived at the facility. -Staff #1 carried Client #1 to the car and took him to the hospital. -Could not remember the time of the incident but thought it may have been between "12:30pm and 1:00pm." -Client #1 did not know how to adjust the water temperature. -"I have never seen it (water temperature) go so hot." -Staff #2 checked the water temperature after the incident and it was "117" degrees Fahrenheit. Interview on 8/21/25 with Staff #3 revealed: -Staff #1 phoned requesting assistance between 12:00pm and 1:00 pm on 8/19/25. -Staff #1 said that he left Client #1 in the bathroom to get his belongings from another room. -Staff #1 said that he heard the water running and when he returned to the bathroom Client #1's legs were "submerged in the water." -Staff #1 said that when he put his hand in the water, "it burned his hand."	V 512		

PRINTED: 09/10/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601498	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/28/2025

NAME OF PROVIDER OR SUPPLIER: **ROCKMOOR RIDGE CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **8401 ROCKMOOR RIDGE ROAD CHARLOTTE, NC 28215**

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V 512	Continued From page 12 -Staff #1 said Client #1's burn "didn't look that bad" when he initially saw it. -"When I saw his feet they were burned, like no skin." -Client #1's legs were not burned. -The burn on the left foot covered "all the surface on top." -The burn on the right foot covered "the top of the toe area." -Client #1 "knows how to turn the knob" to turn on the water. -Client #1 "doesn't know the difference between hot and cold." -"I don't leave him (Client #1) alone (in the bathroom)." Interview on 8/21/25 with Staff #2 revealed: -Was out of town on 8/19/25 when the incident occurred. -Performed monthly water temperature checks. -Monthly temperature readings were around 115 or 116 degrees Fahrenheit. -Had no concerns about the water being too hot. -Denied checking the water temperature after the incident. -"He (Client #1) doesn't have any safety awareness and needs constant supervision. He will get into anything." -Client #1 was able to get into the tub and sit down. -"He (Client #1) will turn the water on, but I am the one that sets the temperature." -"I stay in the bathroom with him the whole time." -It was unsafe to leave Client #1 unattended in the bathroom. Interview on 8/26/25 with the Clinical Director revealed: -Learned on 8/20/25 of the incident that occurred on 8/19/25 which resulted in Client #1 being	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601498	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER: ROCKMOOR RIDGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 8401 ROCKMOOR RIDGE ROAD		

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V 512	Continued From page 13 burned and was in the process of conducting an investigation. -Staff #1 had been suspended on 8/20/25 while the facility's internal investigation was completed. -"He (Staff #1) knows where he went wrong...He should have had him (Client #1) by his side." -Staff #2 completed monthly water temperature checks. -Was not aware of any concerns regarding the water temperature prior to Client #1 being burned. Interview on 8/26/25 with the Licensee revealed: -Water temperature checks were completed monthly by Staff #2. -The water heater was adjusted on 8/21/25 after learning from the Division of Health Service Regulation (DHSR) surveyor that the water temperature in the bathroom where the incident occurred was 118 degrees Fahrenheit. -Staff #1 said he panicked when he saw the burns on Client #1. -Staff #1 did not call 911 or the Qualified Professional at the time of the incident, he called Staff #3. Review on 8/27/25 of the Plan of Protection dated 8/27/25 written by the Clinical Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. The direct support staff was suspended pending investigation from working at [licensee] as of 8/20/2025. 2. The clinical director visited the home on 8/21 (2025) and tested the water temperature to ensure it was within 100-116 3. Staff will have a quick guide for safety measures in their consumer daily notebook that they have with them everyday. The AFL homes will also have these safety quick guides posted in	V 512		

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V 512	Continued From page 14 their homes. Also; we will have this in [electronic medical record] where daily notes are done by staff. Describe your plans to make sure the above happens. 1. The monitoring specialist will now be equipped with a digital thermometer and required to take the temperature of all water sources that member (client) will have access to beginning 9/1/2025. 2. The AFL provider, back up staff, and day staff for the members of the home will be recertified in first aid/CPR (cardio pulmonary resuscitation) training as of 9/3/2025 3. Emergency protocol procedures will be reviewed and staff will be tested on their knowledge of protocols by 9/3/2025 4. Monitoring specialist will ensure beginning 9/1/2025 that all AFL homes have the quick guide for CPR/First Aid posted in the home." Client #1 was diagnosed with Unspecified Convulsions; Autistic Disorder; Unspecified Mood Disorder; Conduct Disorder, Unspecified; Cerebral Palsy, Unspecified; Severe Intellectual Developmental Disability. Client #1 required close supervision and full physical assistance with regulating water temperature. On August 19, 2025, Staff #1 reported that he left Client #1 in the bathtub to gather his clothes, towel and soap. During this time, Client #1turned on the hot water. Upon Staff #1's return, he found Client #1 in a partially filled tub of hot water, resulting in severe burns with blistered and peeled skin on both feet, requiring hospitalization. This deficiency constitutes a Type A1 rule violation for serious neglect and harm and must be corrected within 23 days.	V 512		