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EAST MAIN STREET GROUP HOME	610 EAST MAIN STREET ALBEMARLE, NC 28001

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on April 10, 2026. The complaints NC00236029, NC00236098 were substantiated. Complaint #NC00236578 was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. 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 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills;	V 110		

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V 110	Continued From page 1 (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on records reviews and interviews the facility failed to ensure 1 of 4 audited staff (Former Staff #9) demonstrated knowledge and skills required by the population served. The findings are: Review on 4/7/26 of Client #1 (Cl #1)'s record revealed: -Admission date of 3/28/13. -Diagnoses of Moderate Intellectual Disability, Thrombocytopenia, Unspecified; Resistant hypertension; Cardiomyopathy, Rheumatoid Vasculittis with Arthritis of the Hip; Monoclonal Gammopathy. -Treatment Plan dated : 3/1/26: Goals::"-3. Maintain a healthy lifestyle by way of continuing to attend all medical appointments and taking medications as prescribed. -5. Tailored care management will be provided in order to coordinate and monitor authorized services, ensure collaboration among medical, behavioral health providers and community resources, review and ensure access to medications and collaborate with all care providers so that members needs met across all	V 110		

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V 110	Continued From page 2 areas." Review on 4/7/26 of Client #5 (Cl #5)'s record revealed: -Admission date of 1/27/22. -Diagnosis of Moderate Intellectual Disability. Review on 4/7/26 of Former Staff #9 (FS #9)'s record revealed: -Hire date of 11/18/19. -She was hired as a Residential Manager. -Separation date of 3/9/26. Review on 4/6/26 of the facility's Incident Response Improvement System (IRIS) report dated 2/13/26 revealed: -Report submitted by the Residential Team Leader (RTL). -"During conversation on 2/10/2026, [Cl #1's guardian] communicated that she has concerns about [Cl #1's medical care not being managed by the Residential Manager (RM) and multiple missed appointments. Wishes for RM to not continue managing Cl #'1's medical care." Review on 4/7/26 of the faciity's internal investigations revealed: -Submission date: "3/4/26 -Awareness date: "2/10/26." -What is the allegation and who reported it?: "On 2/12/26, [RTL] and Regional Director (RD)] called [Cl #1's Guardian] to discuss recommendations that was received from Human Resources (HR). During this call, the guardian expressed that she does not want [Residential Manager (RM)] to manage Cl #1's medical needs any longer. The guardian then communicated a specific communication that she had with [RM] via text where [RM] expressed that she was not going to be able to transport [Cl #1] to the	V 110		

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V 110	Continued From page 3 Emergency Room (ER); although[CI #1] was demonstrating signs of being sick. The guardian then stated again that she does not want [RM] to manage [CI #1]'s medical care any longer. Based on this communication the complaint was escalated to an allegation of neglect." -What were the inconsistencies?: "There are differences between guardian/reported appointment dates and those documented in internal records. There is conflicting information regarding responsibility for medical scheduling and follow-up communication. [RM] reports timely communication attempts that are not consistent with the guardian's reports of delayed or absent updates. It is not clear as to the issues concerning pickup delays and the reasons given for transport issues. It is not clear why appointments were cancelled and the explanations provided." -Were all policies followed?: "No." -What policies were not followed?: "Service documentation, Investigation, Communication Policy, Incident Reporting of Medical Events." -"The investigation identified contributory risk factors- including inconsistent guardian communication, missed or rescheduled appointments and incomplete documentation. overall review of the evidence demonstrates that acute conditions were escalated promptly and emergency care was obtained when needed; however, chronic issues- including repeated scheduling failures, communication gaps, missed preventive care and breakdowns in guardian-manager trust- constitute significant deficiencies requiting corrective action. It is believed by the investigator that although intentional neglect did not occur, substantial performance and oversight issues must be addressed to ensure reliable medical coordination in the future."	V 110		

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-Recommendations: 2/13/26 "1. The RTL will receive a written disciplinary for violation of Corrective Action Policy. Unsatisfactory Job Performance. Failure to follow through on ensuring the manager was performing her job duties satisfactorily. It was noted in supervisions that performance was an ongoing issue. 2. Training. The RTL will receive coaching on prioritizing individuals health and safety when not feeling while receiving day services. Individuals should not be attending the day program when not feeling well for the convenience of staff. Residential staff are responsible to pick the individual up from the day program and are responsible to provide contact information on the residential location's chain of command for coordination of care. 3. Relocation. {RM} will receive a written warning for violation of corrective action policy, unsatisfactory job performance. [RM]'s position will be terminated. Documentation does not provide clear picture of actions of the team in case notes outlining outcomes and efforts to address concerns. [RM] was also in possession of confidential and private medical records from medical visits and discharges when interviewed. [RM] will be offered a Developmental Specialist Residential role at an alternative location. Failure to accept the relocation will result in termination. In addition, [RM] will no longer be able to participate in management training."
-Submission date: 2/27/26.
-Awareness date: "2/26/26."
-What is the allegation and who reproted it?: "[Cl #1's Legal Guardian] requested a copy of bank books from the last year. [RTL] then emailed the bank books to the guardian for her to review. [CL #1's Legal Guardian] then emailed [RTL and RD] with concerns about the bank books. The guardian questioned a withdrawal of

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$100 that was on 3/13/25. The Individual Cash Receipt (ICR) stated that this $100 withdrawal was to purchase a desk for [CI #1]. [RTL] and [RD] both went to East Main group home to check if a desk was purchased; however, neither [RTL] observed a desk in [CI #1]'s bedroom. Staff was subsequently suspended pending the outcome of an allegation of exploitation."

-What were the inconsistencies?: "Hygiene and toiletry products were reported to be furnished by the guardian but documentation in the records show that these items continued to be purchased in the group home. The Hair appointments could not be definitively verified because the stylist reported not providing receipts but relied on the scheduling in the book and whether or not it had been crossed off. There was a ICR for the purchase of a desk for $100 dollars. There was no desk found by RTL or RD when they checked the home. In the interview with RM, she reported that she had not made the purchase but could not verify where the money may have been spent. She indicated that it could have been put towards a hair appointment or other items. [RM] states ICRs are labeled to match purchases, while her statement suggests an ICR may have been completed for a desk, but funds may have gone toward a hair appointment. The ICRs for money were not signed by a witness and staff could not provide receipts for items purchased. The banking information had been verified by finance based on these reports. There was one ICR with [CI #1]'s signature with no date or amount of money received (signed blank check, found in the investigator's review of the records."

-Were all policies followed?: "No."

-What policies were not followed?: "Personal Funds Policy."

-"Review of the information outlines

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documentation gaps and practices that possibly creates significant risk of financial mismanagement. [RM]'s statements introduce uncertainly regarding whether funds may have been withdrawn and used somewhere else. She noted that she was not able to find a suitable desk (dresser) and may have used the funds for the costs of getting [Cl #1]'s hair done ($13) as it would take a large amount from her funds...Based on the evidence reviewed hair appointments on 2/15/25 and 6/24/25 remain uncertain. There was an ICR for a desk purchase for $100 on 3/13/25. [RM] stated that this purchase was never made. In this case the investigator believes it is unlikely that these funds were used to pay for a second appointment as it is also noted and confirmed by the stylist that [Cl #1] had an appointment on 3/31/25 which was signed off by [RM] for $130."

-Findings: "The internal review team met on 3/4/26 regarding the allegation of exploitation. Based on the information provided we are unable to substantiate exploitation but are able to determine that funds were mismanaged."

-Submission date: "3/6/26."

-What is the allegation and who reported it?: "Based on review of financial record, review of documentation appeared to have irregularities and questionable documentation. [RM] was the person responsible for managing [Client #5]'s funds in her checking account. [Cl #5] was potentially exploited by [RM]. Bankbooks are being reviewed by leadership to determine if exploitation happened. After an initial review of the bank books and financial reports by the guardian, it was reported by the guardian that on two occasion $2000 was taken from [Cl #2]'s account and there are no receipts to explain what these purchases are, just an ICR that states "Spend Down." She did not provide any

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V 110	Continued From page 7 dates...Due to the inconsistencies all persons whose funds are managed by Monarch at East Main were placed under investigation. -What were the inconsistencies?: "1. [RM] stated that guardian approvals were obtained for spend-down purchases; however, documentation of these approvals was not consistently available or retained. 2. [RM] reported that remaining funds from large withdrawals were spent on resident needs the same day, while ICRs and receipts did not consistently support full accounting of those funds. 3. [Client #2] reported minimal staff involvement in her personal fund management, whereas [RM] described providing regular assistance with resident funds, including discretionary expenses. 4. RD reported concerns that [RM] contacted guardians during an investigation, while [RM] was instructed not to contact residents or guardian and stated that approvals were part of routine communication." -What policies were not followed?: "Personal Funds Policy. Investigation Policy." -Conclusions: "The investigation confirmed inconsistent receipt retention, large cash withdrawals without itemized accounting and reliance on informal approval process (Texts). Multiple statements indicate that [RM] contacted guardians after being placed on leave and during an active investigation, including requests for advocacy regarding her employment status...While no direct evidence of intentional financial exploitation was identified, the investigation highlighted serious deficiencies in financial controls, documentation practices in all records. There was also an issue with concern surrounding the adherence to investigation confidentiality requirements by reports that [RM] made contact with guardians after suspension." -Findings: "The internal review team met regarding the allegations of exploitation at East	V 110		

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V 110	Continued From page 8 Main Group home. Based on the information provided, we were unable to substantiate exploitation." -Recommendations: 3/9/26. "1. Termination. Due to poor job performance and mismanagement of person supported funds, it is recommended that [RM] is terminated from Monarch. 2. Other. It is recommended that all persons supported accounts managed by Monarch at East Main are fully audited and evaluated for inaccuracies and irregularities. Instances that items listed on the individual cash receipts cannot be confirmed, they should be submitted to for reimbursement." Interview on 4/6/26 with Client #1's Legal Guardian revealed: -She felt that the facility had not addressed her concerns appropriately. "Things just kept happening for months." -Facility's Director of Nursing was on a call with her and she insisted that RM was a good Manager. -Cl #1 had been in and out of the hospital frequently lately. -On 2/8/26, she went to see Cl #1 and she looked like a zombie. -She found out that Cl #1 had congestive heart failure. She never knew that. Staff never shared that information with her. She found out on her own. She was never notified. -She was informed that the Manager was fired and the facility was trying to hire a new one. -Guardian lived out of town. She had to come to North Carolina in order to help in taking Cl #1 to her appointments. -She "did not feel confident in the facility doing and taking her to the medical appointments." -She felt that "in order to make things right, she had to do them herself."	V 110		

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V 110	Continued From page 9 -Cl #1 was currently on leave from the facility. Legal guardian had her with her. -She was going to a dentist appointment today as Cl #1 had a lose tooth. -Cl #1 had been with her for about a week. -She was told that the facility staff was "trying to take her to the appointments", but she did not trust them. -She wanted to make sure Cl #1 went to her appointments. -Regarding issue with money- She did not know where all the lost money went. -She was told that she would be getting about $1900 back in the next 21 weeks or so. -Plan was for Cl #1 to return to the facility and stay there until guardian found another placement for her. -"Former Manager was super nice, but missed several of [Cl #1]'s medical appointments. -RM would not communicate with them about missed appointments. She would find out after going into Cl #1's Mychart and she would read the missed appointments. -Some of her missed appointments related to RM having called the medical provider to cancel the appointment or to reschedule. -Missed appointments were brought up to the RTL. She tried addressing it first with the RM and then her supervisor. -Cl #1 had missed several appointments. She felt that maybe Cl #1's health would have been better had she not had missed her appointments. -Cl #1 was also recently hospitalized due to low blood pressure. That was when she found her "to be looking like a zombie. Her blood pressure was too low." -"[Cl #1] was taking a medication that required blood pressure tests to be taken prior to the medication as the medicine was to lower the pressure."	V 110		

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V 110	Continued From page 10 -Cl #1 had to be hospitalized due to low blood pressure. -She was told at the hospital that they felt that staff did not take Cl #1's blood pressure prior to administering the medication. Interview on 4/7/26 with Staff 8 revealed: -Staff informed of issues at the facility with the former manager. Reported "she liked to do things her own ways and would not take responsibility when things would not work out. " -"She would also miss client's appointments." -"Staff would always let the Manager know that they were available to assist as needed, but she would try to do things her way, which a lot of times, would not work right." Attempt made on 4/7/26 to contact Former Residential Manager by telephone. -No response. -Unable to locate Former RM. Interview on 4/7/26 with the RTL revealed: -Cl #1 was on therapeutic leave. "She left last Friday. She's with her guardian. She was going to do some medical appointments and her sister is the one that likes to transport her to them if she can. Which they normally do since sister lived out of town, but those kind of appointments, her sister wants to do them herself." -"We don't have a current manager at this time." -She was having to play both roles RM and RTL.) -Social Services had come and interviewed the guardian of one of the individuals (Cl #1). -She did an IRIS report. -"I also reported the potential medical neglect as well. It was the medical neglect what they actually investigated. Not the allegation of exploitation." -In summary, "Cl #1's sister had some complaints about a missed couple of medical appts. We had	V 110		

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a meeting regarding the missed medical appointments. We did not have any more missed appointments after the meeting. This was done in February."
-"While on therapeutic leave, Cl #1 was not feeling well. Her sister took her to medical appointment. During that appointment, she was diagnosed with congestive heart failure. She felt that there was a mismanagement of her medication or that it should have been caught up earlier if the missed appointments had not happened. It may had been prevented.
-The next day, she was taken to another appointment. They basically sent her to the Emergency Room from the appointment and she was hospitalized for a while."
-The allegation of medical neglect came from the missed appointments. "An internal investigation was done and the allegation was unsubstantiated."
-"Some of the missed appointments were due to Cl #1 being in the hospital at the time. Another was because the legal guardian had changed the appointment. He guardian manages her appointments.".
-There was one instance when Cl #1 was taken to her appointment, but when they got there, they were told it had been changed.
-"All the appointments that were missed were rescheduled either because she Cl #1 was in the hospital or because the manager had not been made aware of."
-"There was also an incident when there was another client at the home not feeling well and the manager was not able to provide transportation to [Cl #1]for that appointment."
-"The issue was that that manager could have reach out to me about the situation to see if I could help or reach out to additional staff. "
-"This was already in place. As far as I know, the

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V 110	Continued From page 12 [RM] had not done that when those situations occurred. -CI #1 had been in the hospital due to her blood pressure. "The majority of those times, had been due to her blood pressure. Either been too low or too high." -"When the allegation of abuse was investigated internally. CI #1's chart was also reviewed. Nothing stood out regarding her charts when it was reviewed." -"There was no mismanagement of medications, because the pharmacy sends in the information on the Medication Administration Record (MAR) when we receive the orders from the client's doctor." -"We also had the allegation of exploitation. [CI #1]'s guardian requested copies of that individual's bankbooks. The information was sent. Some transactions were questioned. She wanted to go back about 3 years. An audit of the bank books was made. Conclusion was that the manager didn't follow right procedures." -"With the ICR- Individual cash receipts, the Manager and individual signs the receipts. The manager was not getting second signatures as second witness and not turning in receipts." -"As my understanding. Monarch was going to do paybacks for any questions that Monarch could not prove what definitely happened with the money." -"They could not prove some things, but it did not mean the Manager did not buy what she meant to buy. They just did not have the proof of where the money went. Monarch decided to just pay back the money." -"As a result of the investigation regarding CI #1's money, They ended up reviewing everyone. It only resulted to payback to three different individuals."	V 110		

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V 110	Continued From page 13 -She did not know how much each would be getting back. -"The Manager was terminated because of the misappropriation of the client's personal funds. -There was something that did not match from the receipts. The manager did have the ICR's, but had not followed right procedures." -"The RM was terminated at the beginning of March, but she was previously suspended due to investigations being conducted." Interview on 4/9/26 with the RD revealed: -Regarding allegation of exploitation: "Agency could not proof what really happened with the missing records of the money. The RM did not follow the right procedures." -"Cl #1 was to get about $1900. Client #5 was to get about $2800 back. This was the money computed in the 3 years that the RM was there and which they did not have receipt record." -The finance department had done audits of the client's records every 6 months, but at the time, the CIR's did match the money asked for. -The operations people and finance had met and were working on a policy clarification to make sure it was standard for everyone. They were also working on implementing how much a person could have. It would also be placed on the client's Treatment Plan -RD had only been in current role since November 2025. -She was made aware that there had been a previous Cl #1's team meeting prior to her starting working. It may had been in October 2025. -"When the first allegation occurred, The RM was suspended and an improvement plan was created for her. They then had a "back to back" investigation on RM and she was then terminated."	V 110		

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V 110	Continued From page 14 -"Apparently, there were several missed appointments from the RM. [Cl #1]'s guardian provided several appointments from [Cl #1]' s Mychart. There were several "no shows, cancelled appointments, missed labs prior to [Cl #1]]'s scheduled appointments. -There was also a letter that CL #1's guardian received where it mentioned that she was being dropped from services due to having consecutive missed appointments. When they questioned RM, she could not answer on why those appointments were missed. These appointments were missed sometime last Fall. They had to do something with Cl #1's Depo shots. " -Cl #1 had been hospitalized several times recently. -"A lot of the issues with RM was lack of communication with the manager and her not writing her notes regarding appointments. " -The team lead received a written warning for failure to hold the RM accountable. -For the time being, all of the clients' medical appointments were also being submitted to their section quality control department. Staff at the facility were trained on documentation policy and how to upload client's medical information on the agency's electronic records program (Therap.) -All staff received annual training on Abuse, Neglect, Exploitation. A retraining was part of the improvement plan for the RM prior of her being terminated. Initially, the RM was demoted and wrote up by the RTL. -Regarding client's finances, "A preventive measure is that the agency is working on policy clarification. They will have one process to have for the same thing for everyone. ICP and documentation to back up the request would be mandated for everyone.	V 110		

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V 110	Continued From page 15 -Staff were trained on uploading the medical information on Therap. -"In regards of issues with appointment, if a staff is not able to take a client to their appointment, they should contact their "higher ups." If unable to, it would fall under the staff corrective action for performance. As it would show that 1. Staff did not communication to supervisor and 2. Failed to do job duties."	V 110		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (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. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (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. (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	V 291		

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V 291	Continued From page 16 inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on records reviews and interviews the facility failed to ensure 1 of 4 audited staff (Former Staff #9) demonstrated knowledge and skills required by the population served. The findings are: Review on 4/7/26 of Client #1 (Cl #1)'s record revealed: -Admission date of 3/28/13. -Diagnoses of Moderate Intellectual Disability, Thrombocytopenia, Unspecified; Resistant hypertension; Cardiomyopathy, Rheumatoid Vasculittis with Arthritis of the Hip; Monoclonal Gammopathy. -Treatment Plan dated : 3/1/26: Goals::"-3. Maintain a healthy lifestyle by way of continuing to attend all medical appointments and taking medications as prescribed. -5. Tailored care management will be provided in order to coordinate and monitor authorized services, ensure collaboration among medical, behavioral health providers and community resources, review and ensure access to medications and collaborate with all care providers so that members needs met across all areas." Review on 4/7/26 of Client #5 (Cl #5)'s record revealed: -Admission date of 1/27/22. -Diagnosis of Moderate Intellectual Disability.	V 291		

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V 291	Continued From page 17 Review on 4/7/26 of Former Staff #9 (FS #9)'s record revealed: -Hire date of 11/18/19. -She was hired as a Residential Manager. -Separation date of 3/9/26. Review on 4/6/26 of the facility's Incident Response Improvement System (IRIS) report dated 2/13/26 revealed: -Report submitted by the Residential Team Leader (RTL). -"During conversation on 2/10/2026, [CI #1's guardian] communicated that she has concerns about [CI #1's medical care not being managed by the Residential Manager (RM) and multiple missed appointments. Wishes for RM to not continue managing CI #'1's medical care." Review on 4/7/26 of the faciity's internal investigations revealed: -Submission date: "3/4/26 -Awareness date: "2/10/26." -What is the allegation and who reported it?: "On 2/12/26, [RTL] and Regional Director (RD)] called [CI #1's Guardian] to discuss recommendations that was received from Human Resources (HR). During this call, the guardian expressed that she does not want [Residential Manager (RM)] to manage CI #1's medical needs any longer. The guardian then communicated a specific communication that she had with [RM] via text where [RM] expressed that she was not going to be able to transport [CI #1] to the Emergency Room (ER); although[CI #1] was demonstrating signs of being sick. The guardian then stated again that she does not want [RM] to manage [CI #1]'s medical care any longer. Based on this communication the complaint was escalated to an allegation of neglect." -What were the inconsistencies?: "There are	V 291		

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differences between guardian/reported appointment dates and those documented in internal records. There is conflicting information regarding responsibility for medical scheduling and follow-up communication. [RM] reports timely communication attempts that are not consistent with the guardian's reports of delayed or absent updates. It is not clear as to the issues concerning pickup delays and the reasons given for transport issues. It is not clear why appointments were cancelled and the explanations provided."

-Were all policies followed?: "No."

-What policies were not followed?: "Service documentation, Investigation, Communication Policy, Incident Reporting of Medical Events."

-"The investigation identified contributory risk factors- including inconsistent guardian communication, missed or rescheduled appointments and incomplete documentation. overall review of the evidence demonstrates that acute conditions were escalated promptly and emergency care was obtained when needed; however, chronic issues- including repeated scheduling failures, communication gaps, missed preventive care and breakdowns in guardian-manager trust- constitute significant deficiencies requiting corrective action. It is believed by the investigator that although intentional neglect did not occur, substantial performance and oversight issues must be addressed to ensure reliable medical coordination in the future."

-Recommendations: 2/13/26 "1. The RTL will receive a written disciplinary for violation of Corrective Action Policy. Unsatisfactory Job Performance. Failure to follow through on ensuring the manager was performing her job duties satisfactorily. It was noted in supervisions that performance was an ongoing issue. 2.

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Training. The RTL will receive coaching on prioritizing individuals health and safety when not feeling while receiving day services. Individuals should not be attending the day program when not feeling well for the convenience of staff. Residential staff are responsible to pick the individual up from the day program and are responsible to provide contact information on the residential location's chain of command for coordination of care. 3. Relocation. {RM} will receive a written warning for violation of corrective action policy, unsatisfactory job performance. [RM]'s position will be terminated. Documentation does not provide clear picture of actions of the team in case notes outlining outcomes and efforts to address concerns. [RM] was also in possession of confidential and private medical records from medical visits and discharges when interviewed. [RM] will be offered a Developmental Specialist Residential role at an alternative location. Failure to accept the relocation will result in termination. In addition, [RM] will no longer be able to participate in management training."

Interview on 4/6/26 with Client #1's Legal Guardian revealed:
-She felt that the facility had not addressed her concerns appropriately. "Things just kept happening for months."
-Facility's Director of Nursing was on a call with her and she insisted that RM was a good Manager.
-Cl #1 had been in and out of the hospital frequently lately.
-On 2/8/26, she went to see Cl #1 and she looked like a zombie.
-She found out that Cl #1 had congestive heart failure. She never knew that. Staff never shared that information with her. She found out on her

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own. She was never notified.
-She was informed that the Manager was fired and the facility was trying to hire a new one.
-Guardian lived out of town. She had to come to North Carolina in order to help in taking CI #1 to her appointments.
-She "did not feel confident in the facility doing and taking her to the medical appointments."
-She felt that "in order to make things right, she had to do them herself."
-CI #1 was currently on leave from the facility. Legal guardian had her with her.
-She was going to a dentist appointment today as CI #1 had a lose tooth.
-CI #1 had been with her for about a week.
-She was told that the facility staff was "trying to take her to the appointments", but she did not trust them.
-She wanted to make sure CI #1 went to her appointments.
-Regarding issue with money- She did not know where all the lost money went.
-She was told that she would be getting about $1900 back in the next 21 weeks or so.
-Plan was for CI #1 to return to the facility and stay there until guardian found another placement for her.
-"Former Manager was super nice, but missed several of [CI #1]'s medical appointments.
-RM would not communicate with them about missed appointments. She would find out after going into CI #1's Mychart and she would read the missed appointments.
-Some of her missed appointments related to RM having called the medical provider to cancel the appointment or to reschedule.
-Missed appointments were brought up to the RTL. She tried addressing it first with the RM and then her supervisor.
-CI #1 had missed several appointments. She felt

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that maybe CI #1's health would have been better had she not had missed her appointments.
-CI #1 was also recently hospitalized due to low blood pressure. That was when she found her "to be looking like a zombie. Her blood pressure was too low."
-"[CI #1] was taking a medication that required blood pressure tests to be taken prior to the medication as the medicine was to lower the pressure."
-CI #1 had to be hospitalized due to low blood pressure.
-She was told at the hospital that they felt that staff did not take CI #1's blood pressure prior to administering the medication.

Interview on 4/7/26 with Staff 8 revealed:
-Staff informed of issues at the facility with the former manager. Reported "she liked to do things her own ways and would not take responsibility when things would not work out. "
-"She would also miss client's appointments."
-"Staff would always let the Manager know that they were available to assist as needed, but she would try to do things her way, which a lot of times, would not work right."

Attempt made on 4/7/26 to contact Former Residential Manager by telephone.
-No response.
-Unable to locate Former RM.

Interview on 4/7/26 with the RTL revealed:
-CI #1 was on therapeutic leave. "She left last Friday. She's with her guardian. She was going to do some medical appointments and her sister is the one that likes to transport her to them if she can. Which they normally do since sister lived out of town, but those kind of appointments, her sister wants to do them herself."

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V 291	Continued From page 22 -"We don't have a current manager at this time." -She was having to play both roles RM and RTL.) -Social Services had come and interviewed the guardian of one of the individuals (CI #1). -She did an IRIS report. -"I also reported the potential medical neglect as well. It was the medical neglect what they actually investigated. Not the allegation of exploitation." -In summary, "CI #1's sister had some complaints about a missed couple of medical appts. We had a meeting regarding the missed medical appointments. We did not have any more missed appointments after the meeting. This was done in February." -"While on therapeutic leave, CI #1 was not feeling well. Her sister took her to medical appointment. During that appointment, she was diagnosed with congestive heart failure. She felt that there was a mismanagement of her medication or that it should have been caught up earlier if the missed appointments had not happened. It may had been prevented. -The next day, she was taken to another appointment. They basically sent her to the Emergency Room from the appointment and she was hospitalized for a while." -The allegation of medical neglect came from the missed appointments. "An internal investigation was done and the allegation was unsubstantiated." -"Some of the missed appointments were due to CI #1 being in the hospital at the time. Another was because the legal guardian had changed the appointment. He guardian manages her appointments.". -There was one instance when CI #1 was taken to her appointment, but when they got there, they were told it had been changed. -"All the appointments that were missed were rescheduled either because she CI #1 was in the	V 291		

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hospital or because the manager had not been made aware of."
-"There was also an incident when there was another client at the home not feeling well and the manager was not able to provide transportation to [Cl #1]for that appointment."
-"The issue was that that manager could have reach out to me about the situation to see if I could help or reach out to additional staff. "
-"This was already in place. As far as I know, the [RM] had not done that when those situations occurred.
-Cl #1 had been in the hospital due to her blood pressure. "The majority of those times, had been due to her blood pressure. Either been too low or too high."
-"When the allegation of abuse was investigated internally. Cl #1's chart was also reviewed. Nothing stood out regarding her charts when it was reviewed."
-"There was no mismanagement of medications, because the pharmacy sends in the information on the Medication Administration Record (MAR) when we receive the orders from the client's doctor."
-"We also had the allegation of exploitation. [Cl #1]'s guardian requested copies of that individual's bankbooks. The information was sent. Some transactions were questioned. She wanted to go back about 3 years. An audit of the bank books was made.
Conclusion was that the manager didn't follow right procedures."
-"With the ICR- Individual cash receipts, the Manager and individual signs the receipts. The manager was not getting second signatures as second witness and not turning in receipts."
-"As my understanding. Monarch was going to do paybacks for any questions that Monarch could not prove what definitely happened with the

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money."
-"They could not prove some things, but it did not mean the Manager did not buy what she meant to buy. They just did not have the proof of where the money went. Monarch decided to just pay back the money."
-"As a result of the investigation regarding Cl #1's money, They ended up reviewing everyone. It only resulted to payback to three different individuals."
-She did not know how much each would be getting back.
-"The Manager was terminated because of the misappropriation of the client's personal funds.
-There was something that did not match from the receipts. The manager did have the ICR's, but had not followed right procedures."
-"The RM was terminated at the beginning of March, but she was previously suspended due to investigations being conducted."

Interview on 4/9/26 with the RD revealed:
-RD had only been in current role since November 2025.
-She was made aware that there had been a previous Cl #1's team meeting prior to her starting working. It may had been in October 2025.
-"When the first allegation occurred, The RM was suspended and an improvement plan was created for her. They then had a "back to back" investigation on RM and she was then terminated."
-"Apparently, there were several missed appointments from the RM. [Cl #1]'s guardian provided several appointments from [Cl #1]' s Mychart. There were several "no shows, cancelled appointments, missed labs prior to [Cl #1]]'s scheduled appointments.
-There was also a letter that CL #1's guardian

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V 291	Continued From page 25 received where it mentioned that she was being dropped from services due to having consecutive missed appointments. When they questioned RM, she could not answer on why those appointments were missed. These appointments were missed sometime last Fall. They had to do something with CI #1's Depo shots. " -CI #1 had been hospitalized several times recently. -"A lot of the issues with RM was lack of communication with the manager and her not writing her notes regarding appointments. " -The team lead received a written warning for failure to hold the RM accountable. -For the time being, all of the clients' medical appointments were also being submitted to their section quality control department. Staff at the facility were trained on documentation policy and how to upload client's medical information on the agency's electronic records program (Therap.) -All staff received annual training on Abuse, Neglect, Exploitation. A retraining was part of the improvement plan for the RM prior of her being terminated. Initially, the RM was demoted and wrote up by the RTL. -"In regards of issues with appointment, if a staff is not able to take a client to their appointment, they should contact their "higher ups." If unable to, it would fall under the staff corrective action for performance. As it would show that 1. Staff did not communication to supervisor and 2. Failed to do job duties."	V 291		