

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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	<p>INITIAL COMMENTS</p> <p>A follow up and complaint survey was completed on March 4, 2019. The complaint was substantiated (Intake #NC00148022). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A 27G 5600A Supervised Living for Mentally Ill Adults.</p>	V 000		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and</p>	V 108		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 108	<p>Continued From page 1</p> <p>implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility Management failed to assure that 3 of 4 current staff (#1 #2 #3) and 1 of 1 audited Former staff (FS #5) were currently trained in cardiopulmonary resuscitation (CPR) and First Aid. The findings are:</p> <p>Review on 2/7/19 of Staff #1's record revealed the following information; -- Date of hire 8/24/18. -- Hired as a Paraprofessional. -- No documentation of any CPR or First Aid training.</p> <p>Review on 2/7/19 of Staff #2's record revealed the following information; -- Unable to determine date of hire. -- Hired as a Paraprofessional. -- No documentation of any CPR or First Aid training.</p> <p>Review on 2/7/19 of Staff #3's record revealed the following information; -- Date of hire 7/6/18. -- Hired as a Paraprofessional. -- No documentation of any CPR or First Aid training.</p> <p>Review on 2/7/19 of FS #5's record revealed the following information;</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 108	Continued From page 2 -- Date of hire 1/2/17. -- Left her position in January 2019. -- Hired as a Paraprofessional. -- No documentation of any CPR or First Aid training. Interview on 2/8/19 with the Qualified Professional revealed the following information; -- There are staff who are behind in their trainings. -- It is her responsibility to assure that all staff are current in trainings. -- No explanation was given for these lapses in training.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 3</p> <p>NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.</p> <p>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to assure 1 of 1 Qualified Professional (QP) and 1 of 1 Associate Professional (AP-Medication/Medical Supervisor) demonstrated the knowledge, skills and abilities required by the population served. The findings are:</p> <p>A. Review on 2/13/19 of the QP's record revealed the following information; -- Date of rehire 11/18/17. -- A job description for "Administrator, Dual Population QP" signed by the QP on 11/17/17.</p> <p>Review on 2/13/19 of the QP's job description revealed the following information; -- "Ensuring that the agency's policies, procedures and programs are delivered appropriately is an integral part of this position." "Professional Competency. Support Professionals have competency in the following areas:</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 4</p> <p>d. Crisis Prevention and Intervention-The Support Professional (QP) identifies risk and behaviors that can lead to crisis, and uses effective strategies to prevent or intervene in crisis in collaboration with others...</p> <p>f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and mental health essential to their well-being..."</p> <p>"ESSENTIAL DUTIES AND RESPONSIBILITIES:...</p> <p>Supervision: ...</p> <ul style="list-style-type: none"> -- Participates in staff training opportunities provided by the Agency and any other agencies as requested by the supervisor, and/or required by the State of North Carolina... <p>Functions as Qualified Professional:</p> <ul style="list-style-type: none"> -- Provides clinical oversight for agency services under his/her supervision... -- Develops PCP (Person Centered Plan) for each consumer in conjunction with that consumer's treatment team... -- Evaluates goal progress and completes monthly progress notes for client record... -- Ensures compliance with regulations governing group homes/day programs licensed under DHSR (Department of Health Service Regulation)... -- Reports incidents as required by state guidelines... -- Functions as Qualified Professional and provides clinical oversight and supervision for Supervised Living services... -- Provides clinical supervision to ensure acquisition, retention or improvement in skills related to actives of daily living and social adaptive skills... -- Provides clinical supervision to ensure that habilitation, training and instruction are coupled with elements of support, supervision and 	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 5</p> <p>engaging participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the person's day...</p> <ul style="list-style-type: none"> -- Oversees duties of all service staff (caregivers)... and assures that duties are carried out in a timely and appropriate manner... -- Develops a supervisory plan and provides monthly supervision to each employee and maintains documentation of supervision... -- Provides initial and annual required trainings to all staff and assures that trainings are scheduled and given prior to expiration dates to remain compliant with state guidelines... -- Provides clinical supervision to ensure that interactions with the person are designed to achieve outcomes identified in the plan of care... -- Provides clinical supervision to ensure provision of treatment interventions to ensure that the consumer acquires skills necessary to compensate for or remediate functional problems as outlined in the ISP (Individual Support Plan) and/or person centered plan... -- Reviews documentation in consumer records and personnel records and assures accurate and thorough documentation... <p>ESSENTIAL DUTIES AND RESPONSIBILITIES: Functions as Administrator for homes under his/her supervision:...</p> <ul style="list-style-type: none"> -- Oversees administrative duties regarding payroll, personnel... -- Hires qualified staff, when applicable, and ensures that all duties are carried out in a timely and appropriate manner... -- Reviews consumer records and assures accurate and thorough documentation... <p>Additional Responsibilities Include:...</p> <ul style="list-style-type: none"> -- Delivering service face-to-face with the consumer and in locations outside the I. Innovations Inc.'s facility. 	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 6</p> <p>-- Conducting assessments in the least restrictive environment...</p> <p>-- Addresses all psychiatric, substance abuse, and developmental disability crises for adults to help restore an individual to his/her previous level of functioning..."</p> <p>1. Interview on 2/8/19 with the QP revealed the following information; -- It was her responsibility to provide individual clinical supervision to all the staff. -- She did provide supervision to all of the staff, however this supervision was not documented in the staff records.</p> <p>* See Tag V-110 for additional specific details regarding supervision.</p> <p>2. Interview on 2/8/19 with the QP revealed the following information; -- She was responsible for all 3 client's treatment plans. -- She worked together with the client's Guardian representative Care Coordinators and the Local Management Entitys (LME) from different counties to develop, implement and evaluate these treatment plans.</p> <p>* See Tag V-112 for additional specific details regarding treatment plans.</p> <p>3. Interview on 2/8/19 with the QP revealed the following information; -- She is responsible for all of the aspects of hiring new staff and obtaining required documentation, required training and retraining. -- There is documentation missing in multiple staff records. -- Some staff are behind in participating in required training.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 7</p> <p>* See Tags V-131, V-133, V-536, V-537 for additional specific details regarding hiring and training staff.</p> <p>B. Review on 2/13/19 of the AP-Medication/Medical Supervisor's record revealed the following information; -- Date of hire 4/15/16. -- Hired as a Paraprofessional. -- Currently working in an Associate Professional capacity.</p> <p>Interview on 1/29/19 with the AP-Medication/Medical Supervisor revealed the following information; -- She was in charge of all of the client's medications and their records. -- She had just recently taken over this position and was trying to get the client records organized. -- She confirmed that currently the client's records were unorganized and many things were misfiled and not all of the information in a designated client's record belonged to that client. -- All of the client records were kept at the day program site. -- She worked Monday through Friday from the day program site. -- She confirmed the findings of medications not being administered as ordered by a Physician. -- She confirmed the finding of medication not being stored properly.</p> <p>* See Tag V-118 for additional specific details regarding medication administration and documentation. * See Tag V-120 for additional specific details regarding medication storage.</p> <p>This deficiency is cross referenced into 10A</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 8 NCAC 27G .5601 SCOPE, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.	V 109		
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; (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.	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 110	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility Management: a.) failed to assure 2 of 4 current staff (#2 #4) demonstrated competency when addressing the needs of clients (Client #2) and b.) failed to assure Paraprofessional staff received supervision from a Qualified Professional (QP) or Associated Professional (AP) affecting 4 of 4 current staff (#1 #2 #3 #4) and 1 of 1 audited former staff (FS #5). The findings are:</p> <p>FINDING #1 Review on 1/29/19 of Client #2's record revealed: -- Admitted to the facility on 7/21/16. -- Diagnoses include Schizoaffective Disorder-Bipolar Type, Mild Intellectual Disability, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Suicidal Ideation (Resolved), Diabetes Mellitus-Type II, Hypothyroidism, Asthma, Obesity and GERD (Gastroesophageal Reflux Disorder). -- Adjudicated incompetent and has a court appointed Guardian Representative.</p> <p>During interview on 1/29/19, Client #2 reported: - She has a "weak bladder" and sometimes is unable to hold her urine. - She does not like Staff #8 because she teases her and calls her "Pissy Pants" when she has a bladder accident. - The staff also took her tablet "for a couple of days" as a result of this behavior. - She felt the staff also forced her to go to the Day Activity program when she did not want to go after her bladder accident. - She was very upset, stayed upset and cried most of the day while at the Day Activity program. - Her home does not have a television so Staff #4</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 110	<p>Continued From page 10</p> <p>asked her for her personal Netflix password and she shared it. She said "I felt I had to."</p> <ul style="list-style-type: none"> - Staff #4 subsequently put additional charges on the account and she was unable to make the payments so she no longer has access. <p>During interview on 2/7/19, the QP and AP-Medical/Medication Supervisor reported:</p> <ol style="list-style-type: none"> 1. Regarding Staff #4 <ul style="list-style-type: none"> - an awareness Staff #4 was unable to convince Client #4 to come to Day Activities the day she had the bladder accident. - They were also aware the staff and client had conflict surrounding the client's behaviors which consequently required the AP-Medical/Medication Supervisor to go to the facility to assist in transporting the client to the Day Activity Program. - However, both denied they were aware Staff #4 engaged in name calling and teasing Client #2 and had not taken additional action as a result. 2. Regarding Staff #2 <ul style="list-style-type: none"> - Both management staff were aware of the actions of Staff #2. They reported the situation and staff were dealt with. - The AP-Medical/Medication Supervisor provided a copy of an undated report she completed of circumstances surrounding the incident: "On December 11, 2018 [Client #2] came to me complaining that [Staff #2] (an employee of I Innovations Inc) pressured her into giving up her Netflix password. [Client #2] gave in and was unable to get [Staff #2] off the account, so she could not use her own services. So she [Client #2] had to upgrade the service and pay more money to be able to watch for herself. She ([Client #2]) asked if we can get [Staff #2] off (her Netflix account) without any retaliation against her. I reported this incident to my supervisor [QP] and was told to give a written statement of the 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 110	<p>Continued From page 11</p> <p>events."</p> <p>During additional interview on 2/7/19, the AP-Medical/Medication Supervisor reported the following consequences were implemented in response to Staff #2's actions with Client #2:</p> <ul style="list-style-type: none"> - Staff #2 was temporarily suspended from the schedule and placed on probation for 90 days. The staff received counseling and will receive additional training in client's rights. - Staff #2 was reassigned to work 1 on 1 with another client and no longer works with Client #2. <p>FINDING #2 Review on 2/7/19 of Staff #1's record revealed the following information;</p> <ul style="list-style-type: none"> -- Date of hire 8/24/18. -- Hired as a Paraprofessional. -- No documentation of any individual supervision by a QP or AP. <p>Review on 2/7/19 of Staff #2's record revealed the following information;</p> <ul style="list-style-type: none"> -- Unable to determine date of hire. -- Hired as a Paraprofessional. -- No documentation of any individual supervision by a QP or AP. <p>Review on 2/7/19 of Staff #3's record revealed the following information;</p> <ul style="list-style-type: none"> -- Date of hire 7/6/18. -- Hired as a Paraprofessional. -- No documentation of any individual supervision by a QP or AP since August 2018. <p>Review on 2/7/19 of Staff #4's record revealed the following information;</p> <ul style="list-style-type: none"> -- Date of hire 2/20/18. -- Hired as a Paraprofessional. -- No documentation of any individual supervision 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 110	<p>Continued From page 12</p> <p>by a QP or AP since August 2018.</p> <p>Review on 2/7/19 of FS #5's record revealed the following information;</p> <ul style="list-style-type: none"> -- Date of hire 1/2/17. -- Left her position in January 2019. -- Hired as a Paraprofessional. -- No documentation of any individual supervision by a QP or AP since August 2018. <p>Interview on 2/8/19 with the QP revealed the following information;</p> <ul style="list-style-type: none"> -- Staff participated in staff meetings and received training on providing services to clients every payday from the facility's Program Manager. -- This supervision staff received was not documented. -- Staff personnel files did not contain documentation they had received individualized supervision from a QP or AP based on individualized supervision plans. <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 110		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 13</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility Management failed to assure that a) all medications were administered to clients on the written order of a Physician affecting 1 of 3 audited clients (#1), b) failed to assure that Physician's orders were followed affecting 2 of 3 audited clients (#1 #3), c) failed to assure MARs were kept current affecting 1 of 3 audited clients (#1), and failed to assure competency was displayed in the area of medication administration, documentation and storage by the Associate Professional (AP)-Medication/Medical Supervisor affecting 2 of 3 audited clients (#1 #3). The findings are:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 14</p> <p>Finding #1: Review on 1/29/19 of Client #1's record revealed the following information; -- Admitted to the facility on 8/11/16. -- Diagnoses include Schizoaffective Disorder-Bipolar Type, Bipolar Disorder, Dementia, Cerebellar Atrophy, PTSD (Post Traumatic Stress Disorder), Histrionic Features, HTN (Hypertension), Dyslipidemia, Anemia, GERD (Gastroesophageal Reflux Disorder), Obesity and Chronic Renal Insufficiency. -- "IQ is low at 53 which suggest mild to moderate Intellectual Disability." -- Adjudicated incompetent and has a court appointed Guardian Representative.</p> <p>Interview on 1/29/19 with the Qualified Professional (QP) on 1/29/19 revealed the following information; -- Client #1 was admitted to the hospital on 1/24/19 with a diagnosis of Acute Encephalopathy (Encephalopathy refers to a range of conditions that damage the brain's structure or function. This includes brain damage and brain disease). -- She was admitted through the hospital emergency room on the advice of her primary care Physician who she was seeing on that date due to being sick. -- She was unsure of when the client would be discharged.</p> <p>Interview on 1/29/19 with the AP-Medication/Medical Supervisor revealed the following information; -- She was in charge of all of the clients medications and their records. -- She had just recently taken over this position and was trying to get the client records organized. -- She confirmed that currently the client's records</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 15</p> <p>were unorganized and many things were misfiled and not all of the information in a designated client's record belonged to that client.</p> <p>-- All of the client records were kept at the day program site.</p> <p>-- She worked Monday through Friday from the day program site.</p> <p>1. Review on 1/31/19 of Client #1's hospital discharge summary dated 1/29/19 revealed the following information;</p> <p>-- Hospitalized from 1/24/19 through 1/29/19.</p> <p>-- Discharge Diagnoses: Acute Encephalopathy, Sepsis due to bilateral Pneumonia with left lower extremity (leg) Cellulitis, Hypomagnesemia (not enough Magnesium in the body). (Sepsis is a potentially life-threatening condition caused by the body's response to an infection. The body normally releases chemicals into the bloodstream to fight an infection. Sepsis occurs when the body's response to these chemicals is out of balance, triggering changes that can damage multiple organ systems.)</p> <p>-- "We did add some Lasix to help with lower extremity swelling..."</p> <p>-- "Electrolytes were replaced with continued Magnesium replacement at the time of discharge..."</p> <p>-- "Discharge Diet: Cardiac Diet."</p> <p>-- "Follow-up Instructions:... On antibiotics, Can drink Gatorade for oral fluid replacement in case of diarrhea rather than regular water, Keep both legs elevated when resting."</p> <p>-- New medication orders;</p> <p>-- Doxycycline 100 mg. every 12 hours for 7 days. "Take next dose Tues. 1/29 9:00 pm."</p> <p>-- Amoxicillin 875 mg. every 12 hours for 7 days. "Take next dose Tues. 1/29 9:00 pm."</p> <p>-- Clavulanate Potassium 10 mEq. every day. "Take next dose Wed. 1/30."</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 16</p> <p>-- Furosemide (Lasix) 20 mg. every day. "Take next dose Wed. 1/30." -- Magnesium Oxide 400 mg. twice a day for 5 days. "Take next dose Tues. 1/29 9:00 pm."</p> <p>Additional review on 1/31/19 of Client #1's hospital discharge summary dated 1/29/19 revealed the following information; -- "Cellulitis is a bacterial skin infection. The infected area usually gets red and sore. This condition occurs most often in the arms or lower legs. It is very important to get treated for this condition so the infection does not continue to spread." -- "If you were prescribed an antibiotic medicine, take it as told by your Doctor. DO NOT stop taking the antibiotic even if you start to feel better." -- "Drink enough fluid to keep your pee (urine) clear or pale yellow." -- "Raise (elevate) the infected area above the level of your heart while you are sitting or lying down."</p> <p>-- "Pneumonia is an infection of the lungs... it is easy for this to spread from person to person..." -- "If you were prescribed an antibiotic medicine, take it as told by your Doctor. DO NOT stop taking the antibiotic even if you start to feel better." -- "Drink enough fluid to keep your pee (urine) clear or pale yellow." -- "You may also prevent pneumonia if you take these actions: ...Wash your hands often. If soap and water are not available, use hand sanitizer."</p> <p>-- "What is Amoxicillin and Clavulanate Potassium? Amoxicillin is a penicillin antibiotic that fights bacteria in the body. Clavulanate Potassium is a beta-lactamase inhibitor that helps prevent certain bacteria from becoming resistant</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 17</p> <p>to Amoxicillin. Amoxicillin and Clavulanate Potassium is a combination medicine used to treat many different infections caused by bacteria such as Pneumonia, infections of the skin..."</p> <p>-- "Use this medicine for the full prescribed length of time. Your symptoms may improve before the infection is completely cleared. Skipping doses may also increase your risk of further infection that is resistant to antibiotics."</p> <p>-- "What is Doxycycline? Doxycycline is a tetracycline antibiotic that fights bacteria in the body.:</p> <p>-- "Use the medicine exactly as directed... Use this medicine for the full prescribed length of time. Your symptoms may improve before the infection is completely cleared. Skipping doses can increase your risk of infection that is resistant to antibiotics."</p> <p>-- "What is Furosemide? Furosemide is a loop diuretic (water pill) that prevents your body from absorbing too much salt... it is used to treat fluid retention (edema)..."</p> <p>-- "Furosemide will make you urinate more often and you may get dehydrated easily."</p> <p>-- "Avoid becoming dehydrated. Follow your doctor's instructions about the type and amount of liquids you should drink while you are taking Furosemide."</p> <p>Review on 1/31/19 of Client #1's January 2019 MAR revealed no transcriptions for, nor documentation that the client was administered any Doxycycline, Amoxicillin, Clavulanate Potassium, Lasix or Magnesium Oxide.</p> <p>Interview on 1/31/19 with the AP-Medication/Medical Supervisor revealed the following information;</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 18</p> <ul style="list-style-type: none"> -- Client #1 had been discharged from the hospital back to the facility on 1/29/19. -- She had not gotten a chance to review the client's discharge summary from the hospitalization. -- She was unaware that the client was discharged with 5 new medications to be administered daily. -- She confirmed that at the time of this interview, the client had missed multiple doses of these medications for almost 2 days. -- She confirmed that Client #1 was not being served a Cardiac diet. <p>Interview on 2/13/19 with Client #1 revealed the following information;</p> <ul style="list-style-type: none"> -- Slow garbled speech and yawning. -- Sitting slumped down in the chair. -- She was drooling excessively onto her shirt. -- She knew that she had been in the hospital, but was unable to state anymore about that. -- Knows that she takes medications, but doesn't know the names of them. <p>2. Review on 1/31/19 of Client #1's record revealed a letter written by her Psychiatrist dated 6/28/17 with the following information;</p> <ul style="list-style-type: none"> -- "...She (Client #1) has a very long history of mental illness and has been very violent in the past. It is recognized that she is on a large number of medications with similar mechanisms of action and purpose. Unfortunately small reductions in medications have lead to increased irritability and aggressive behavior. Both the Keppra and the Depakote DR appear instrumental in helping prevent physical violence directed at others. I am willing to assume prescribing responsibilities for these two medications..." 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 19</p> <p>Additional review on 1/31/19 of Client #1's record revealed another letter written by her Psychiatrist dated 10/10/18 with the following information; -- "[Client #1] has been under my care since 2/13/17. She is on a large number of psychiatric medications, all of which are clinically indicated and approved by her Guardian. Although she displays a number of side effects from these medications, [Client #1] requires these medications in order to live in the least restrictive environment possible outside of the inpatient psychiatric hospital." -- "...[Client #1] has been repeatedly hospitalized and incarcerated..." -- Hospitalization dates including one that lasted for 4 & 1/2 years, and the last one occurring from 2010 through 2016. -- "While in [name of the last psychiatric hospital], [Client #1] was tried on multiple medications for psychosis and aggression without success... She required multiple physical holds and periods of seclusion due to aggression and was frequently on 1:1 or 2:1 precautions... Complicated combinations of medications were required to get her symptoms under enough control to allow for discharge..." -- "Upon release from [name of the last psychiatric hospital], an outpatient Psychiatrist was concerned about the number of her medications and her side effects. Her medications therefore reduced and she once again became aggressive, punching staff members in the head. Her care was thus transferred to our clinic." -- " It is unfortunate that [Client #1] requires such a large number of medications that cause her to have side effects. Without these medications, however, she is quite dangerous and cannot be managed in the community and will require either rehospitalization or incarceration..."</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 20</p> <p>-- "I do not consider it clinically appropriate or ethically appropriate to reduce any of her medications when the result would be disastrous with worsened psychotic symptoms and overt unprovoked violent behaviors towards those around her. All of her medications are felt to be necessary for her to be able to function successfully outside of an inpatient psychiatric facility."</p> <p>Review on 1/31/19 of Client #1's record revealed an FL-2 dated 7/4/18 with the following Physician's orders;</p> <p>-- Zyprexa 15 mg. every day. -- Zyprexa 20 mg. every day. -- Ativan 0.5 mg. every day. -- Ativan 2 mg. at bedtime.</p> <p>Review on 1/31/19 of Client #1's record revealed a Physician's visit summary dated 1/22/19 written by the client's new Primary Care Physician with the following information;</p> <p>-- "She (Client #1) is accompanied with a staff member to the appointment who has only been working with Innovations for a few months now and barely knows the client. Pt. (Patient only knows about her Reflux)..."</p> <p>-- "Bipolar I; currently seeing [name of Psychiatrist] for psychiatric medications, sees her every 3 - 6 months. Context: unpredictable mood swings (reported by staff member for unknown reasons pt. has many 'writeups' in system for being disruptive). Severity: severe..."</p> <p>-- "Psychiatric Exam: General Appearance: alert and disheveled. Behavior: guarded and does not make eye contact. Affect: blunted, restricted, flat and limited range. Thought Processes: attention wandered throughout interview. Thought Content: hallucinations, judgement is impaired." -- [Name of same Psychiatrist] is prescribing</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 21</p> <p>Seroquel 200 mg., Depakote 500 mg., Zyprexa, Ativan, Vistaril. Clozaril and Atropine." -- "[Name of facility pharmacy] also reports [name of different Physician] was co prescribing Ativan, Zyprexa 15 mg." -- "Medication list had been updated today to eliminate all the co-prescribed medications. -- Discontinue Zyprexa 15 mg. and Ativan 0.5 mg.</p> <p>Review on 1/31/19 of Client #1's January 2019 MARs revealed that neither the Zyprexa 15 mg. nor the Ativan 0.5 mg. had been discontinued and documentation reflecting administration of these 2 medications from 1/23/19 through 1/31/19.</p> <p>Interview on 2/6/19 with the Medication/Medical Supervisor revealed the following information; -- The Physician writing the discontinue orders should not be discontinuing the orders of other Physician's.</p> <p>Based on review of documentation and due to the failure to accurately document medication administration, it could not be determined if Client #1 was administered her medications as ordered by the Physician.</p> <p>Finding #2 Review on 1/29/19 of Client #3's record revealed the following information; -- Admitted on 8/7/17. -- 24 years old. -- 2006 psychological testing resulting in a full scale IQ of 40. -- Diagnoses include Mild Mental Retardation, Disruptive mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), Borderline Personality Disorder, Fetal Alcohol Syndrome, Learning Disability, Attention Deficiet Hyperactivity Disorder, Mood Changes, Diabetes</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 22</p> <p>Mellitus-Type II, Seizure Disorder, Asthma, Chronic Constipation, Hypothyroid, GERD (Gastroesophageal Reflux Disorder) and Urinary Incontinence.</p> <p>-- Adjudicated incompetent and has a court appointed Guardian Representative since 2012.</p> <p>-- An FL-2 dated 6/19/18 with a Physician's order for a Diabetic Diet.</p> <p>** Refer to tag V-120 Medication Requirements for complete information regarding medication storage.</p> <p>Review on 1/31/19 of Client #3's November, December 2018 and January 2019 MARs revealed the following information;</p> <p>-- Finger stick blood sugar readings for the client were recorded daily.</p> <p>-- These blood sugar readings were very difficult to read as staff was documenting the reading in very small boxes on the MARs.</p> <p>-- January 2019's blood sugars ranged from 103 to 396.</p> <p>-- December 2018's highest blood sugar reading was 420, the lowest number could not be determined due to the inability to read most of the documentation on the MAR.</p> <p>-- November 2018's highest blood sugar reading was 340, the lowest number could not be determined due to the inability to read most of the documentation on the MAR.</p> <p>Observation on 2/27/19 at 2:50 pm of the facility refrigerator revealed the following;</p> <p>-- 2 opened (in use) Lantus Insulin pens.</p> <p>-- 2 opened Victoza Insulin pens.</p> <p>-- None of these 4 pens had anything documented on them indicating the date that they were opened (Insulin is only useable for 30 days following being opened, and should be disposed</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 118	<p>Continued From page 23 of after that).</p> <p>Review on 2/27/19 of information on the packaging of both the Lantus Insulin and the Victoza Insulin revealed that "to reduce pain at the injection site" the opened Insulin pens should be kept at room temperature.</p> <p>Interview on 1/31/19 with the AP-Medication/Medical Supervisor revealed the following information; -- She thought the Insulin stored in the refrigerator was in a locked box. -- She was aware that the client's blood sugar readings were hard to decipher on the MARs. -- She was going to have the staff start recording the blood sugar reading on a flow sheet. -- She confirmed that Client #3 was not being served a Diabetic diet.</p> <p>By the exit date of this survey (3/4/19) no changes to how staff document client blood sugar reading had been implemented.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 118		
V 120	<p>27G .0209 (E) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36</p>	V 120		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 120	<p>Continued From page 24</p> <p>degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility Management failed to assure that all medications stored in a refrigerator were kept in a separate locked container affecting 1 of 1 client (#3) requiring refrigeration for medications. The findings are:</p> <p>Review on 1/29/19 of Client #3's record revealed the following information; -- Admitted on 8/7/17. -- 24 years old. -- 2006 psychological testing resulting in a full scale IQ of 40. -- Diagnoses include Mild Mental Retardation, Disruptive mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), Borderline Personality Disorder, Fetal Alcohol Syndrome, Learning Disability, Attention Deficiet Hyperactivity Disorder, Mood Changes, Diabetes Mellitus-Type II, Seizure Disorder, Asthma, Chronic Constipation, Hypothyroid, GERD (Gastroesophageal Reflux Disorder) and Urinary Incontinence.</p>	V 120		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 120	<p>Continued From page 25</p> <p>-- Adjudicated incompetent and has a court appointed Guardian Representative since 2012. -- A Physician's order dated 5/11/18 for Lantus Insulin 30 units subcutaneously at bedtime. -- A Physician's order dated 1/8/19 for Victoza Insulin 1.2 mg. subcutaneously every day.</p> <p>Observation on 2/27/19 at 2:50 pm revealed the following Insulin stored in the facility refrigerator door loose and unlocked; -- 3 unopened boxes of Lantus Insulin 100u/ml. each containing 5 Insulin pens. -- An opened box of Lantus Insulin 100u/ml. with 4 full unused pens. -- 2 opened used Lantus Insulin pens, one with 220 units of Insulin remaining in the pen, and the other with 160 units of Insulin remaining in the pen. -- An opened box of Victoza Insulin 18 mg/3ml. with 1 full unused pen. -- 2 opened used Victoza Insulin pens, one with 12 mg. of Insulin remaining in the pen and the other with 9 mg. of Insulin remaining in the pen.</p> <p>Interview on 2/27/19 with staff confirmed that Client #3's Insulin was not stored in a locked container in the facility refrigerator, and couldn't remember there ever being a locked container for refrigerated medications.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 120		
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 131	<p>Continued From page 26</p> <p>REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p> <p>This Rule is not met as evidenced by: Based on interview and record review the facility Management failed to assure that a check of the Health Care Personnel Registry (HCPR) was obtained to hire affecting 1 of 4 current staff (#2). The findings are:</p> <p>Review on 2/7/19 of Staff #2's record revealed the following information; -- Unable to determine date of hire. -- Hired as a Paraprofessional. -- No evidence of a check of the HCPR.</p> <p>Interview on 2/8/19 with the Qualified Professional revealed the following information; -- It is her responsibility to hire and obtain all required documentation for new staff. -- No explanation was given for not performing the required check, or not obtaining the required documentation.</p>	V 131		
V 133	<p>G.S. 122C-80 Criminal History Record Check</p> <p>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 133	Continued From page 27 "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 133	<p>Continued From page 28</p> <p>history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. 	V 133		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 133	<p>Continued From page 29</p> <p>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</p> <p>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</p> <p>(7) The subsequent commission by the person of a relevant offense.</p> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 133	<p>Continued From page 30</p> <p>General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 133	<p>Continued From page 31</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility Management failed to assure that a criminal history background check was requested within 5 days of an offer of employment affecting 1 of 4 current staff (#2). The findings are:</p> <p>Review on 2/7/19 of Staff #2's record revealed the following information; -- Unable to determine date of hire. -- Hired as a Paraprofessional. -- No evidence a criminal history background check was requested.</p> <p>Interview on 2/8/19 with the Qualified Professional revealed the following information; -- It is her responsibility to hire and obtain all required documentation for new staff. -- No explanation was given for not performing</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 133	Continued From page 32 the required check, or not obtaining the required documentation.	V 133		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 289	<p>Continued From page 33</p> <p>serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to provide residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation of individuals who have a mental illness, a developmental disability or substance abuse disorder, and who require supervision affecting 3 of 3 clients (#1 #2 #3). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0203</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 289	<p>Continued From page 34</p> <p>COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS, Tag V-109. Based on interview and record review, the facility management failed to assure 1 of 1 Qualified Professional (QP) and 1 of 1 Associate Professional (AP-Medication/Medical Supervisor) demonstrated the knowledge, skills and abilities required by the population served.</p> <p>Cross-Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS, Tag V-110. Based on interview and record review, the facility Management: a.) failed to assure 2 of 4 current staff (#2 #4) demonstrated competency when addressing the needs of clients (Client #2) and b.) failed to assure Paraprofessional staff received supervision from a Qualified Professional (QP) or Associated Professional (AP) affecting 4 of 4 current staff (#1 #2 #3 #4) and 1 of 1 audited former staff (FS #5).</p> <p>Cross-Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS, Tag V-118. Based on observation, interview and record review, the facility Management failed to assure that a) all medications were administered to clients on the written order of a Physician affecting 1 of 3 audited clients (#1), b) failed to assure that Physician's orders were followed affecting 2 of 3 audited clients (#1 #3), c) failed to assure MARs were kept current affecting 1 of 3 audited clients (#1), and failed to assure competency was displayed in the area of medication administration, documentation and storage by the Associate Professional (AP)-Medication/Medical Supervisor affecting 2 of 3 audited clients (#1 #3).</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 289	<p>Continued From page 35</p> <p>Cross-Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS, Tag V-120. Based on observation and interview the facility Management failed to assure that all medications stored in a refrigerator were kept in a separate locked container affecting 1 of 1 client (#3) requiring refrigeration for medications.</p> <p>Review on 3/4/19 of the Plan Of Protection written by the Owner/Licensee and dated 3/4/19 revealed the following information; "What immediate action will the facility take to ensure the safety of consumers in your care? Medication Storage: Owner purchased a Medication Storage Box on 3/4/2019 with lock to store medication in to include (insulin) at 5023 Valley View Drive, Sanford, NC 27330. Medication Administration: A Medication Administration Training was conducted on 3/2/2019 for all direct care staff. Treatment Plans: All Mental Health Treatment plans are in the process of being reviewed to ensure compliance to include listing medication. This said, a clinical team meeting is scheduled for 3/5/19 @3:00 PM to review and update each member's plan to include listing medication(s). Diets: I Innovations, Inc.'s Owner, Program Manager, to include Quality Assurance will conduct a clinical team meeting on 3/4/19 to review each member's ISP (Individual Support Plan) that resides an 5023 Valley View Drive, Sanford, NC to make sure that each member's diet plan is being met and addressed; to include diabetic diet. This said, the team will create a weekly meal plan calendar for each consumer to include a diabetic diet plan for the individuals that have one. The meal plans for each consumer will be placed in a binder at the residential home and day support center if applicable. The Qualified Professional (QP) will review the</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 289	<p>Continued From page 36</p> <p>meal plans with all direct care staff who work with the member's who have a meal plan to include diabetic meal plans. QP will conduct monthly supervision with the direct care staff members to make sure that the meal plans are being addressed.</p> <p>QP Competency: The Owner and Program Manager will conduct a meeting with the LM (?), Qualified Professional to review her roles and responsibilities as a QP on 3/5/18. This said, the QP's job duties and responsibilities will be reviewed and modified as needed to ensure compliance with the service definition. The QP will receive monthly supervisions to ensure compliance with the QP's roles/responsibilities.</p> <p>The QP is required to obtain required training/refreshers to ensure compliance with providing quality services.</p> <p>Staff Training: The Owner and Quality Management will conduct an in-house audit to review HR (Human Resources) charts on 3/5/19 to ensure compliance; to include required trainings. This said, individuals that need updated training(s) will be required to attend the outdated trainings to ensure compliance. Quality management will review the agency's 2019 Training Calendar with all staff members to make sure they know when trainings are scheduled. The 2019 Training Calendar will be posted on the employee bulletin board at the Day Support center.</p> <p>Describe your plans to make sure the above happens: I Innovations, Inc.'s Owner, program manager, to include Quality Assurance designated a time line to complete the identified deficiencies on 3/4/19. The team will work together immediately to make sure that all of the identified deficiencies are being corrected in a timely manner; to include a</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 289	<p>Continued From page 37</p> <p>mandatory quality assurance follow up meeting that will take place 3/8/19. (minutes will be taken to ensure compliance). -- Responsible party: Owner, Program Manager, and Quality Assurance -- Time Line: Immediate Action required, 3/4/19. The team will meet as a group again on 3/8/19 to discuss progress and updates regarding issues/deadlines. Immediate Action is required for all deficiencies."</p> <p>Client #1, Client #2 and Client #3 have complex medical and psychological diagnoses. Administrative/management staff and facility staff did not implement or follow physician orders for Client #1's medications following a 5 day hospitalization (1/24/19-1/29/19) for a serious medical problem (Acute Encephalopathy-a condition that affects the brain structure and function.). The facility was unaware Client #1 was discharged from the facility with 5 new medications that were to be administered daily, causing Client #1 to miss 2 days of prescribed medication. The facility did not maintain current and legible medication administration records for Client #3 whose daily blood sugar readings could not be determined due to an inability to read the documentation. Client #3 had identified readings as high as 420 since November 2018. Client #3's Insulin was not stored securely and safely as required, and not stored properly per manufacturer's guidelines to reduce injection site pain and maintain medication potency. The facility failed to provide Physician ordered therapeutic diets for 2 client's to assist in prevention of additional medical complications. Staff #2 pressured Client #2 to give her the password to Client #2's Netflix account and this lead to Client #2 being unable to access her Netflix account. Client #2 had to upgrade her</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 289	<p>Continued From page 38</p> <p>service and pay a higher fee to be able to Netflix for herself. Staff #4 engaged in teasing and name calling at Client #2 for having toileting accidents. The QP responsible for staff supervision, training and required hiring procedures (to assure client safety) failed to maintain accurate documentation and/or obtain required training.</p> <p>These systemic failures resulted in serious neglect and constitute a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of \$2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 289		
V 536	<p>27E .0107 Client Rights - Training on Alt to Rest. Int.</p> <p>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 536	<p>Continued From page 39</p> <p>gathered.</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <ol style="list-style-type: none"> (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace 	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 536	<p>Continued From page 40</p> <p>behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(6) Trainers shall have coached experience</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 536	<p>Continued From page 41</p> <p>teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility Management failed to ensure 1 of 4 current staff</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC - 5023 VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5023 VALLEY VIEW SANFORD, NC 27330
--	--

(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 536	<p>Continued From page 42</p> <p>(#1) and 1 of 1 former staff (FS #5) received annual training updates in alternatives to restrictive interventions. The findings are:</p> <p>Review on 2/7/19 of Staff #1's record revealed the following information; -- Date of hire 8/24/18. -- Hired as a Paraprofessional. -- No current annual training update in alternatives to restrictive interventions.</p> <p>Review on 2/7/19 of FS #5's record revealed the following information; -- Date of hire 1/2/17. -- Left her position in January 2019. -- Hired as a Paraprofessional. -- No current annual training update in alternatives to restrictive interventions.</p> <p>Interview on 2/8/19 with the Qualified Professional revealed the following information; -- There are staff who are behind in their trainings. -- It is her responsibility to assure that all staff are current in trainings. -- No explanation was given for these lapses in training.</p>	V 536		