STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032356	A. BUILDING: _____ B. WING _____	12/21/2021

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INEZ'S HOUSE HC	2811 INDEPENDENCE AVENUE DURHAM, NC 27703

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on December 21, 2021. The complaint was unsubstantiated (intake #NC00184147.) Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample was three current clients, one former client.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and	V 367		

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V 367	Continued From page 1 (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:	V 367		

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V 367	Continued From page 2 (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a Level II incident report was completed and submitted to the Local Managed Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 12/21/21 of Former Client #4 (FC #4)'s record revealed: -Admission date of 6/4/09. -Discharge date of 11/28/21. -Diagnoses of Mental Retardation; Diabetes; History of Seizures. Review on 12/21/21 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There were no reports made about FC #4 since	V 367		

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V 367	Continued From page 3 3/7/2013. Interview on 12/21/21 with Staff #1 revealed: -There was one medical emergency in November. -He got informed one morning by FC #4 that he had blood coming out from his penis. -He called for an ambulance and tried to keep him calmed. -He assisted FC #4 to get ready to go to the hospital while waiting for the ambulance. -Ambulance came to the house and took FC #4 to the hospital. Interview on 12/21/21 with the Qualified Professional revealed: -FC #4 had to go to the hospital in November. -She attempted to do an IRIS report for FC #4. -She knew that she needed to do an IRIS report. -She had been getting chemo therapy at the hospital when FC #4 went to the same hospital. -She completed an internal report. -Due to her health, she was sick from her chemo. -She was unable to get the report in. -She was waiting for additional information from the Doctor in order to put it on the report. -She was then not sure if it was too late to submit the report. -In the event that she was not able to complete an IRIS report, the Owner could have completed it, but she felt pride on her work and did not inform the Owner that the report had not been submitted yet. -She would submit the incident report in IRIS with notation that it was a late submission. -She acknowledged the facility failed to ensure a Level II incident report was completed and submitted to the Local Managed Entity/Managed Care Organization (LME/MCO) within 72 hours.	V 367		

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V 367	Continued From page 4 Interview on 12/21/12 with the Owner revealed: -The Qualified Professional was responsible for submitting incident reports to IRIS. -FC #4 had to go to the hospital in November because there was blood in his urine. An ambulance was called to transport him. -FC #4 went to the hospital via an ambulance. -She was under impression that the Qualified Professional had submitted an incident report for the event.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are: Observation on 12/21/21 at about 1:32 pm of the Hallway upstairs revealed: -The paint on the wall near doorframe leading to the kitchen was peeling off. Observation on 12/21/21 at about 1:40 pm of Client #1's room revealed: -The wood panels under the window had rot on the bottom.	V 736		

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V 736	Continued From page 5 -The dresser was missing knobs from the top drawers. Observation on 12/21/21 at about 1:42 pm of the downstairs bathroom revealed: -Wood panel sections from the door were peeled off on the bottom. Observation on 12/21/21 at about 1:45 pm of the outside revealed: -There was an old box spring in the back that needed to be thrown away. Interview on 12/21/21 with the Qualified Professional revealed: -Facility was not taking any new clients at the time because they wanted to do some remodeling. -She took note of things that needed to be repaired and will inform the owner. -House belonged to the Owner. -Agency was responsible for making repairs at the house. -She confirmed that the facility failed to ensure grounds were maintained in a clean, safe and attractive manner.	V 736		