STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-062	A. BUILDING: _____ B. WING _____	R 08/03/2022

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SCI-SIMMONS	801 SIMMONS STREET GOLDSBORO, NC 27530

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on August 3, 2022. The complaint was substantiated (intake #NC00190718). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 5 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132		

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V 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR). The findings are: Review on 8/02/22 of North Carolina Incident Response Improvement System (IRIS) reports dated 5/01/22 - 8/02/22 revealed no level III incident reports submitted by the facility. During interview on 8/02/22 a representative of the Division of Mental Health/Developmental Disability/Substance Abuse Services Customer Service and Community Rights team revealed: - An IRIS report was created by the provider regarding an incident that occurred on 6/24/22	V 132		

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V 132	Continued From page 2 that involved client #1. - The report was incomplete and was not submitted. Review on 8/02/22 of an IRIS report provided by the Executive Director revealed: - An incomplete report that included "Date of Incident: 6/24/2022." - ". . . Incident Information: . . . Does this incident include an allegation against the facility? Yes . . . " - No detailed information about the incident/allegation, no information regarding notification of the allegation to the HCPR. - Typewritten statements signed by the Qualified Professional (QP) attached to the incident report included: - "6/27/22 Statement from [client #2] [Client #2] states [former staff #15] will yell and talk junk to them during her shift." - "6/27/22 Statement from [client #4] . . . he stated [former staff #15] 'talks junk,' 'has a smart mouth' and 'fusses and yells all the time.' . . . He stated that she called [client #1] a 'toothless pervert.' . . . He stated that [former staff #15] talks down to them all the time." - A handwritten statement dated 6/27/22 and signed by former staff #15 attached to the incident report included " . . . On a particular day while describing his actions in the moment of him touching me I called those actions perverted. My choice of word was not in a way to describe him it was regarding his actions." - A letter of termination dated 6/30/22 addressed to former staff #15 attached to the incident report included " . . . we conducted an investigation into an allegation that you called a client a 'toothless pervert.' We are substantiating this allegation. . . . " - Former staff #15 was separated from her employment effective 6/30/22 for " . . . calling	V 132		

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V 132	Continued From page 3	V 132		

clients by a degrading name . . . conduct that puts a client at risk of physical or psychological harm . . ." and for making remarks to clients that "would be considered derogatory or inappropriate."

During interview on 8/02/22 client #1 stated former staff #15 called him "a name" but would not elaborate of repaat the name former staff #15 called him.

During interview on 8/02/22 client #2 stated:
- Former staff #15 was disrespectful of him and his peers.
- Former staff #15 would yell at him and his peers
- Former staff #15 made inappropriate statements to client #1 "all the time" but he could not remember specifically what she said.

During interview on 8/02/22 client #4 stated:
- Former staff #15 "kept calling him [client #1] an ugly name."
- Former staff #15 had called client #1 names multiple times.
- Former staff #15 said "ugly stuff" to him "once or twice."

During interview on 8/02/22 former staff #15 stated:
- She no longer worked at the facility.
- She had not worked at the facility in over two months and she did not understand why she was contacted by the surveyor.
- She had not witnessed, suspected, nor taken part in any verbal or physical abuse of the facility clients.

During interviews on 8/02/22 and 8/03/22 the Group Home Director stated:
- An investigation was initiated as soon as the Licensee learned of the allegation against former

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V 132	Continued From page 4 staff #15. - The QP was responsible for entering and submitting IRIS reports. - She did not realize the IRIS report provided was not complete, nor that HCPR had not been notified of an allegation of abuse. - She would discuss the deficiency with the QP and ask the QP to complete and submit the IRIS report including notification to the HCPR. The QP was not available for interview.	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.	V 366		

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V 366	Continued From page 5 (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides,	V 366		

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V 366	Continued From page 6 if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to a level III incident as required. The findings are:	V 366		

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V 366	Continued From page 7 Review on 8/02/22 of North Carolina Incident Response Improvement System (IRIS) reports dated 5/01/22 - 8/02/22 revealed no level II or level III incident reports submitted by the facility. During interview on 8/02/22 a representative of the Division of Mental Health/Developmental Disability/Substance Abuse Services Customer Service and Community Rights team revealed: - A level III IRIS report for an incident that occurred on 6/24/22 was present in the IRIS system. - Client #1 was named in the report. - The report was incomplete and was not submitted. Refer to tag V132 for specific information regarding level III incident report for incident dated 6/24/22. - Former staff #15 allegedly called client #1 a "toothless pervert" on 6/24/22. - The provider conducted an internal investigation and the allegation of abuse was substantiated. - Former staff #15 was separated from her employment for " . . . calling clients by a degrading name . . . conduct that puts a client at risk of physical or psychological harm . . ." and for making remarks to clients that "would be considered derogatory or inappropriate." Review on 8/02/22 of an IRIS report provided by the Executive Director revealed: - "Date of Incident: 6/24/2022 . . . Does this incident include an allegation against the facility? Yes . . . " - No documentation of attendance to the health and safety needs of the client #1; no determination of the cause of the incident; no development or implementation of corrective	V 366		

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V 366	Continued From page 8 measures to prevent similar incidents; no assignment of persons responsible for the implementation of corrections and preventive measures; documentation of notification of client #1's guardian. During interviews on 8/02/22 and 8/03/22 the Group Home Director stated: - An investigation was initiated as soon as the Licensee learned of the allegation against former staff #15. - The QP was responsible for entering and submitting IRIS reports. - She did not realize the IRIS report provided was not complete, nor that HCPR had not been notified of an allegation of abuse. - She would discuss the deficiency with the QP and ask the QP to complete and submit the IRIS report including notification to the HCPR. The QP was not available for interview.	V 366		
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,	V 367		

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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
(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

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V 367	Continued From page 10 client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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 reviews and interviews the facility failed to ensure critical incident reports were submitted as required. The findings are: Refer to tags V132 and V366 for specific information regarding level III incident report for	V 367		

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V 367	Continued From page 11 incident dated 6/24/22.. Review on 8/02/22 of North Carolina Incident Response Improvement System (IRIS) reports dated 5/01/22 - 8/02/22 revealed no level II or level III incident reports submitted by the facility. During interview on 8/02/22 a representative of the Division of Mental Health/Developmental Disability/Substance Abuse Services Customer Service and Community Rights team revealed: - A level III IRIS report for an incident that occurred on 6/24/22 was present in the IRIS system. - Client #1 was named in the report. - The report was incomplete and was not submitted. During interviews on 8/02/22 and 8/03/22 the Group Home Director stated: - An investigation was initiated as soon as the Licensee learned of the allegation against former staff #15. - The QP was responsible for entering and submitting IRIS reports. - She did not realize the IRIS report provided was not complete, nor that HCPR had not been notified of an allegation of abuse. - She would discuss the deficiency with the QP and ask the QP to complete and submit the IRIS report including notification to the HCPR.	V 367		