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V 000	INITIAL COMMENTS A complaint survey was completed on October 24, 2022. The complaints were substantiated (intakes #NC00194054 and #NC00193974). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental Vocational Programs for Individuals with Developmental Disabilities The facility has a current census of 32. The survey sample consisted of audits of 3 current clients.	V 000		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for	V 512		

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V 512	Continued From page 1 dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff neglected one of three audited clients (#1). The findings are: Review on 10/20/22 of Client #1's record revealed: -Admission date of 4/16/16. -Diagnoses of Mild Intellectual Disability, Athetoid Cerebral Palsy, Scoliosis, History of Gastroesophageal Reflux. -Day Program attendance: Tuesday-Friday from 8:15 a.m. to 2:30 - 3p.m. -One-on-One at the day program -Transportation provided by private company. -Wheelchair during the day until bedtime. -Adult Depends. -Pureed foods orally and Gastrostomy Tubes (G-Tube) for liquids including medication. -Day Support Goals dated 10/2022 included the following: "-client will be checked every 2 hours while at the day program and changed twice daily to prevent any moisture build up/pressure sores from occurring. -client will receive assistance with protecting his arms and hands when maneuvering his wheelchair through doorways, hallways and other entrance and exits. -while at the day program staff will check client's G-Tube to ensure there are no leaks and it is connected correctly. -client will hydrate with a total of 12-16 ounces of water during a 6-hour period while at the day program. -client will be encouraged to increase his solid	V 512		

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food intake portions more often throughout the day.
-client will eat his lunch in a quiet area so that he is not distracted by others.
-client skin will be cleaned and given ointments or creams as needed (i.e., feet, genitals, bottom and hands)."

Review on 10/24/22 of the Incident Report dated 9/20/22 regarding Client #1 revealed:
- "[Client #1's] mother called on the evening of 9/20/22 and reported that [Client #1] arrived home from MID Innovations Day program that day of 9/20/22 and [Client #1] was wet, as Depends were not changed. [Client #1's] mother also indicated that [Client #1] did not receive [Client #1's] snack of chocolate pudding, did not receive [Client #1's] lunch meal, did not

receive [Client #1's] ensure feeding. [Client #1's] mother reported that [Client #1] sat in the room and did not receive staff attention ..."

Interview on 10/21/22 with Client #1's mother revealed:
-Client #1 returned home from the day program on 9/20/22.
-Client #1 had a home care worker that worked with him before and after the day program.
-Home care worker notified her about concerns on how client #1 returned home from the day program.
-Client #1's home care worker sent her pictures of the contents in his lunchbox.
-The lunch box contained, pureed lunch, snack, liquid medication, and bottle of water.
-Client #1 was prescribed Diazepam and Gabapentin.
-Client #1 did not receive the items left in his lunchbox.

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V 512	Continued From page 3 -Client #1 received his medication and an eight-ounce bottle of water to flush the G-Tube. -The milk pump and formula still had the contents in it. -Client #1's pants and Depends were wet. -Client #1 did not get his snack, pureed lunch or milk. -She reported client #1 was not attended to. -She had issues in the past with the day program but nothing comparable to current incident. -There was never a day that client #1 never received his food. -She previously addressed issues with changing the Depends and ensuring client #1 was hydrated. -On 9/20/22 she contacted the Director of Quality Management (DQM) after talking to the home care worker. -DQM told her client #1's one-on-one was not scheduled to work. -They were supposed to have a backup staff and that staff did not show up. -Client #1 only received his medication and water. -Client #1 was supposed to get snack at 10:00 a.m. and milk after lunch, about 1:00 p.m. -She was told the day program had staff comfortable working with the G-Tube. -She was told by DQM that staff #2 gave client #1 water and medication. -Not sure if staff #2 was told to do anything else. -Staff #2 went back to working with her assigned client. -She was always advocating, calling, and holding staff accountable. -Constant contact was always with the DQM. - "I would call [DQM] if something was not right or went wrong." -She and DQM discussed an action plan after the incident. -An action plan and schedule were put in place.	V 512		

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-The service plan indicated: client #1 did not like to be alone or by himself.
-Sent client #1 to the day program for socialization and to be around friends.

Interview on 10/20/22 with Staff #2 revealed:
-She worked 8:30 a.m. - 2:30 p.m., Monday-Friday.
-She provided 1:1 service with another client.
-The DQM asked her to administer client #1's medication on 9/20/22.
-She had previous experience working with another client that had a G-Tube.
-There was one hole for the medication and one hole for liquid food.
-She administered client #1's medication at 10 a.m. and 1:00 p.m. through the G-Tube.
-After she administered client #1's medication she returned to her client.
-Client #1 was in the recreation room both times.
-She was not comfortable working with client #1.
-Client #1 touched and said inappropriate comments to her.
-DQM was aware of it.
-DQM was at the day program on 9/20/22.
-"They (DQM and QP) knew [client #1] was in the recreation room."

Interview on 10/20/22 with Staff #3 revealed:
-She worked PRN (as needed) at the day program.
-She worked at the group home, day program and drove the bus.
-She was a fill-in when client #1's 1:1 did not work.
-She asked that Human Resources (HR) to notify her ahead of time for coverage.
-Worked with client #1 previously for 2 or 3 months in 2020.
-She described what was required to work with

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V 512	Continued From page 5 Client #1. -Client #1 had to be fed, change his depends, and administer medication. -Client #1's mother wanted his G-Tube rinsed with 4 ounces of water in the morning. -Client #1 had lunch at 11:00 a.m. and she would find someone to help change his diaper. -She needed assistance lifting client #1 from the wheelchair. -She would give client #1 milk, his afternoon medication and lunch. -She checked client #1's G-Tube throughout the day to ensure it was not clogged. -She would also check to see if ointment was needed when she changed client #1's depends. -Client #1 would be fed his pureed food by mouth for lunch. -Client #1's mother sent his personal items and food to the day program. Interview on 10/20/22 with the Qualified Professional revealed: -She started working 9/15/22. -There were 4 clients in wheelchairs at the day program. -Everyone did not have a written schedule to change depends. -There was not a formal schedule but client #1's 1:1 worker was aware of his needs. -Client #1 was the only client that had a G-Tube. -There was no schedule for client #1 upon her arrival. -Client #1 had a 1:1. -A written schedule was implemented after client #1's mother filed a grievance on 9/20/22. -Client #1's mother reported that his lunch box was not empty. -She believed there was a schedule once before in client #1's folder. -Client #1 used a G-Tube for his milk, water and	V 512		

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liquid medication and snack and lunch was fed orally.
-Food was pureed and provided by client #1's mother.
-Client #1's food came in a cooler and his lunch had to be warmed up.
-Client #1 received his medication and had his G-Tube flushed.
-She was not aware client #1 did not receive his food until his mother filed a grievance on 9/20/22.
-Client #1's 1:1 staff did not come to work on 9/20/22.
-She did not know client #1's 1:1 staff was not coming to work.
-No other staff had worked with client #1 for a long time.
- "Some staff tried to help out."
-Staff #2 said she would administer client #1's medication.
-She was present when staff #2 administered client #1's morning medication.
-Medication administration took about 5 or 10 minutes.
-She was not present when staff #2 administered client #1's afternoon medication.
-There was no discussion with her around who would work with client #1.
- "I don't believe [client #1] was changed that day."
- "There was no actual assignment for [client #1]."
-She started to make phone calls once she learned client #1's 1:1 was not coming to work.
-The 1:1 usually came in between 8:30 a.m. - 9:00a.m.
-She learned the 1:1 was not on the schedule about 9:00 a.m.
-Human resources did the scheduling.
-Another staff was assigned to work with client #1 but was a no show.
-Client #1 was sitting in the recreation room with

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V 512	Continued From page 7 other clients and staff. -Clients and staff rotated in and out of the recreation room. -There were at least 14 staff working plus her and the administrative assistant. -Client #1 preferred female staff. -She was not trained to work with client #1. -She was under the assumption that staff #2 would change client #1's diaper. -She was not sure the reason staff #2 did not change client #1's depends. -She thought client #1 was going to be covered when staff #2 was assigned to administer his medication. -She was not sure if client #1's clothing was wet and how soiled his diaper was. -Staff #3 was the preferred fill-in staff. -Some people were not comfortable working with the G-Tube. -There was no instruction for caring for client #1. -She did not have a meeting, conversation or training to discuss the incident with staff. -She only spoke to the 1:1 and staff #2 about the concerns the next day. -They had staff that were willing to work with client #1 but needed to be trained. -She usually greeted clients in the morning. "-It could have been the administrative assistant or me that moved [client #1] from the recreation room to the transportation van." -Client #1 did not have a staff assigned to him on 9/20/22. Interview on 10/20/22 and 10/24/22 with the DQM revealed: -A system was in placed when clients arrived at the day program. -Staff checked clients in upon arrival. -He was at the day program earlier in the day on 9/20/22.	V 512		

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V 512	Continued From page 8 - "Was there maybe one hour." - "Not sure what time the 2nd staff was supposed to arrive." -There was a miscommunication between HR and the QP. -They were looking for client #1's 1:1 to show up. -They thought she was a no call no show. -Found out the 1:1 was off the schedule. -HR had the schedule and there was a miscommunication with scheduling. -The QP was not aware of the schedule. -HR had the 1:1 staff and another staff scheduled that did not show up. -Client #1 did not have an assigned staff and they were dealing with staff shortage. -Client #1 was in the recreation room. -Staff would go in and out of the recreation room. -The recreation area was to watch videos and exercise. -Staff #2 was supposed to administer the medication. -There was a discussion that Staff #2 was going to do the medication and find someone to feed client #1 orally. -QP indicated that she told Staff #2 to do the feeding. -Client #1 did not receive his lunch or snack. -Staff #2 was assigned to another client. -Staff #2 did not understand that she was supposed to feed client #1 orally. -The assigned staff that did not show up would have been able to change client #1's depends. -He could not say if there was a gap of services for client #1 between 10:00 a.m. -1:00 p.m. -He reported it could not be determined how long it took staff #2 to administer medication. -Staff #2 returned to her client after administering client #1's medication. -He had no idea who moved client #1 from the recreation room to the transportation van.	V 512		

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-Client #1's mother would be informed of the backup staff going forward.
-Backup staff would be trained by shadowing client #1's 1:1 staff.
-Training was scheduled with a consultant on 10/21/22 at 9 a.m.
-Client #1's schedule was implemented upon his mother's approval.
-Staff #3 and the 1:1 staff worked with client #1 since the incident.
-They were unable to identify staff without cameras that was in the recreation room.
-"The assumption would have been that client #1 was being watched."

Review on 10/24/22 of the Plan of Protection written by the Director, Quality Management dated 10/24/22 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?

The QP provided in-service training to Mid Carolina Innovations (MCI) staff on Abuse, Neglect Prevention on October 21, 2022. The in-service sheet with staff signatures was scanned to Division of Health Services Regulation on 10/21/22.

The QP (manager) held a staff meeting for Mid Carolina Innovations on October 21, 2022, to address supervision and support to all members, and discussion of the [Client #1's] incident and reporting protocols. The in-service sheet with staff signatures was scanned to Division of Health Services Regulation (DHSR) on 10/21/22.

The Provider took action immediately after the event of 9/20/22. The schedule was implemented 9/21/22 as staff 1:1 was assigned to member [Client #1], with an experienced alternate [Staff

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V 512	Continued From page 10 #3]. Both staff had previously worked with the member [Client #1]. There has been no exceptions of staff assignments since the event of 9/20/22. The Manager (QP) at MCI has monitored staff assignments for all members-daily on the floor at MCI since the event of 9/20/22 and ensured that [Client#1] and any other members receive required staff support as outlined in the treatment plan and based on their needs. The QP continues to monitor assignments daily at MCI on an ongoing basis. [Client #1] has continued to receive the required staffing and support since the event of 9/20/22, and in advance of this DHSR survey with no exceptions. The QP will complete daily documentation of her monitoring activity at the day program. The Director of Operations and Director of Quality Management will conduct weekly monitoring at the day program to ensure continued compliance and will complete documentation of the monitoring activity as well. The QP has scheduled staff meeting every 2 weeks at MCI to address any concerns that staff may have regarding member services and/or supports. The staff meetings will be documented and available for review. *This provider contends that the findings do not support a need for a plan of protection as there was no evidence present to represent a threat to a client's safety and health. The schedule was implemented on 9/21/22, the next day after the event and there has been no exceptions. Describe your plans to make sure the above happens.	V 512		

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V 512	Continued From page 11 Quality Management Director and the Director of operations will monitor to ensure the actions are in place and documented accordingly. " Client #1 is a 30-year-old man diagnosed with Mild Intellectual Disability, Athetoid Cerebral Palsy, Scoliosis and Gastroesophageal Reflux by history. Client #1 lives with his mother and attends the day program from Tuesday to Friday at 8:45 a.m. to 2:30 p.m. Client #1 has a 1:1 staff due to the support needed including G-Tube feeding with medication and flushing, repositioning him in the wheelchair, feeding pureed meals and changing his Depends. On 9/20/22 Client #1 was left in the recreation room all day without staff supervision and support. Although Client #1 received his medication and flushing at 10:00 a.m. and 1:00 p.m., he was not changed and did not receive his lunch, snack, ensure or juice. Client #1 returned home with all items in his lunchbox and with soiled Depends and pants. The facility demonstrated failure to provide the needs and services required while client #1 was in their care on 9/20/22. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administration penalty of $1,500.00 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.	V 512		