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	MHL053-072	A. BUILDING: _____ B. WING _____	C 08/22/2024

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I INNOVATIONS, INC	317 WEST MAIN STREET SANFORD, NC 27330

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V 000	INITIAL COMMENTS A complaint survey was completed on August 22, 2024. The complaint was unsubstantiated (intake #NC00220587). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness and 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups. This facility is licensed for 0 and has a current census of 7. The survey sample consisted of audits of 2 current clients, 1 former client.	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	V 132		

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facility or to a patient or client.
e. Fraud against a health care facility or against 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 ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are:

Review on 8/16/24 of Former Client #8's (FC) record revealed:
-Admission date of 4/11/24.
-Discharge date of 8/14/24.
-Diagnoses of Intellectual Disability Mild, Major Depressive, Unspecified Trauma and Stressor, and Disruptive Mood Dysregulation Disorder.

Review on 8/16/24 of Staff #1's personnel record revealed:
-Hire date of 8/2/21.
-Paraprofessional.

Review on 8/19/24 of the hospital report dated 8/8/24 revealed:
-"[FC #8] is an 18-year-old female with a history of depression, anxiety, affect dysregulation, and impulsiveness that presented to the emergency department via Emergency Medical Services (EMS) after having an altercation with a staff member at her group home. [FC #8] currently

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V 132	Continued From page 2 denies any Suicidal Ideation/Homicidal Ideation/Auditory Visual Hallucinations SI/HI/AVH. [FC #8] says that she has had any issue with 1 staff members and have arguing back and for the with a staff member over the past day. [FC #8] says that she walked out the group home and staff member attempted to get her back, which resulted in a physical altercation. [FC #8] says that the staff member pulled her back into the group home ended up poking her in the eye, and the police were contacted. [FC #8] states that she has been in Department of Soical Services (DSS) custody since she was 18-month-old. [FC #8] says that she does not want to go back to the group home secondary to having this altercation. Review on 8/16/24 of the facility's records revealed: -There was no documentation that HCPR was notified of an allegation of abuse against Staff #1 related to FC #8. Review on 8/16/24 of an in-house incident report revealed: -8/8/24- "[FC #8] was sitting in the free area at the day program. [FC #8] went to the bathroom. [FC #8] was in the bathroom for about 20 minutes. Staff checked on [FC #8] and she said she was alright. [FC #8] came out of the bathroom and walked out the back door. Staff saw [FC #8] and went out to redirect her. [FC #8] had walked to the street. Staff gave [FC #8] several VP (verbal prompts) to return to the building. [FC #8] did not comply. Staff continued to walk behind [FC #8] to return to the building. [FC #8] began to attack staff and using profanity. Staff used Nonviolent Crisis Intervention (NCI) training to assist [FC #8]. [FC #8] fell to the ground staff continued to give [FC #8] verbal prompt to calm down. [FC #8] continued to use profanity towards staff. [FC #8]	V 132		

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V 132	Continued From page 3 got up and continued screaming and cursing at staff. [FC #8] came in the building and continued her behavior. Staff continued to give [FC #8] VP to calm down. Staff was instructed by [The Owner] to call 911. Staff did. [FC #8] stated she wanted to go to the hospital. [FC #8] went with EMS to the hospital." Review of the North Carolina Incident Response Improvement System (IRIS) on 8/16/24 revealed: -The level III incident was reported to The Owner on 8/9/24. -The level III incident report was submitted to IRIS on 8/13/24. -The facilty did not complete the form on IRIS for HCPR. Interview on 8/20/24, with Local Management Entity/Managed Care Organization (LME/CO)revealed: -"I received a call from [Local Hospital Social Worker] Friday evening (8/9/24) saying that [FC #8] was involved in a physical altercation with a male staff on 8/8/24." -"I called the group home [Owner] and provided them with the information of an allegation regarding [FC #8] on 8/9/24." Interview on 8/16/24 with the Qualified Professional (QP) revealed: -"I didn't notify the HCPR because I was on a cruise when the incident occurred." -"When I got back from vacation, I didn't know what paperwork was completed." -"I don't know why [Owner] didn't notify the HCPR." Interview on 8/19/24 with the Owner revealed: -"The lady from [LME/CO] called me on 8/9/24, I can't remember her name and told me about the	V 132		

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V 132	Continued From page 4 accusations [FC #8] made." -"[FC #8] said that staff drugged her across the rocks." -"The lady at [LME/CO] told me that it was noted that [FC #8] did not have any bruises to correlate to the fact that she was drugged." -"I did not report the incident to HCPR because I didn't think to report it."	V 132		
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 (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any	V 367		

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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:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet

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V 367	Continued From page 6 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 interview, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 8/16/24 of Former Client #8's [FC] record revealed: -Admission date of 4/11/24. -Discharge date of 8/14/24. -Diagnoses of Intellectual Disability Mild, Major Depressive, Unspecified Trauma and Stressor, and Disruptive Mood Dysregulation Disorder. Review on 8/16/24 of an in-house incident report revealed: -8/8/24- "[FC #8] was sitting in the free area at the day program. [FC #8] went to the bathroom. [FC	V 367		

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V 367	Continued From page 7 #8] was in the bathroom for about 20 minutes. Staff checked on [FC #8] and she said she was alright. [FC #8] came out of the bathroom and walked out the back door. Staff saw [FC #8] and went out to redirect her. [FC #8] had walked to the street. Staff gave [FC #8] several VP (verbal prompt) to return to the building. [FC #8] did not comply. Staff continued to walk behind [FC #8] to return to the building. [FC #8] began to attack staff and using profanity. Staff used Nonviolent Crisis Intervention (NCI) training to assist [FC #8]. [FC #8] fell to the ground staff continued to give [FC #8] verbal prompt to calm down. [FC #8] continued to use profanity towards staff. [FC #8] got up and continued screaming and cursing at staff. [FC #8] came in the building and continued her behavior. Staff continued to give [FC #8] VP to calm down. Staff was instructed by [Owner] to call 911. Staff did. [FC #8] stated she wanted to go to the hospital. [FC #8] went with EMS to the hospital." Review of the North Carolina Incident Response Improvement System (IRIS) on 8/16/24 revealed: -The level III incident was reported to [Owner] on 8/9/24. -The level III incident report was submitted to IRIS on 8/13/24. Interview on 8/16/24 with the Qualified Professional (QP) revealed: -"When I got back from vacation on 8/12/24, [Owner] told me to put the incident in IRIS." -"I started putting the information into the system on 8/12/24 and finished on 8/13/24." -"I don't know what was completed because I was on vacation." -"I don't why [Owner] did not put the report in IRIS while I was on vacation."	V 367		

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V 367	Continued From page 8 Interview on 8/19/24 with the Owner revealed: -"I did not put the report in IRIS because I didn't think about it."	V 367		