STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-901	A. BUILDING: _____ B. WING _____	R 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURO RESTORATIVE - WINDEMERE	3601 WINDEMERE PLACE RALEIGH, NC 27604

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V 000	INITIAL COMMENTS An Annual, Follow Up and Complaint Survey was completed November 1, 2019. The complaint was substantiated (Intake #NC00157290). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and	V 106		

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V 106	Continued From page 1 (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to its transportation policy. The finding is: Review on 11/01/19 of the facility's transportation policy revealed "Transporting adults may be one of your responsibilities as an employee. The destinations are numerous and varied, but one thing remains constant: your responsibility to provide transportation. This is a great deal of responsibility and will require an extra measure of caution and preparation." Review on 10/25/19 of the facility's records revealed the following internal incident reports between March-October 2019: -03/03/19 at 6:30 PM: Staff #1 drove the company vehicle and "backing out sideswiped the yellow barrier." Former client #10 was inside the vehicle located on the passenger side. Damage to the company vehicle occurred on the passenger rear side occupied by FC #10. Incident occurred in a parking lot. -07/31/19 at 5:30 PM: Staff #2 had three clients loaded on the company vehicle headed towards an outing. He backed the facility's van into another employee's car. The company vehicle hit the employee's car on the driver's side which resulted in damage to the employee's car.	V 106		

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V 106	Continued From page 2 During interview on 10/25/19 and 11/01/19, staff #1 reported: 10/25/19: In 2018, she was involved in an incident in which FC #10 fell while on the lift. A company investigation yielded the incident resulted an issue with the lift not staff competency. Since March 2019, she had been involved in one incident with the company vehicle. She had taken three clients to volunteer at a local program that delivered meals for low income and the elderly. One client had been out of the vehicle too long and she went to assist with redirecting him back toward the company vehicle. The company vehicle rolled backwards and another client attempted to stop the vehicle. However, she was able to stop the vehicle and secure the break and put the car in park. She thought she had placed the gear shaft in the park position. Management was aware and discussed with her the importance of placing the car in park upon exiting the vehicle. 11/01/19: She had forgotten about the 03/03/19 vehicle incident. She recalled stopping to get something for the client to eat. As she backed out the parking lot, she heard a noise that indicated she had hit something. Management discussed with her how to back out and cautioned her to be more careful. During interview on 10/30/19, staff #2 reported: -After 07/31/19, Management provided a verbal coaching with him regarding being more aware of his surroundings when he backed up. In addition. management reiterated to staff procedures on where employees cars should be parked. In this case, the employee was not parked in a parking space. During interview on 11/01/19, the Program Director reported:	V 106		

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V 106	Continued From page 3 - His agency provided training annually for staff regarding transportation. The training (inclusive of video, written test and skill test of the non ambulatory lift on the van) did not include a skill driving test. 2019 training had not been completed as of this interview, however, the training was scheduled within the upcoming three weeks. -After each of the incidents noted above, he coached staff regarding safe driving techniques.	V 106		
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	V 367		

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V 367	Continued From page 4 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: (1) medication errors that do not meet the	V 367		

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V 367	Continued From page 5 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 ianterview, the governing body failed to report Level II incident reports as required to the Local Management Entity (LME). The findings are: Review on 10/29/19 of the LME Review on 10/15/19 of the facility's records revealed no incident reports in the North Carolina Incident Response Improvement System (IRIS). Review on 10/25/19 of the facility's records revealed the following internal incident reports between March-October 2019: -03/03/19 at 6:30 PM: Staff #1 drove the company vehicle and "backing out sideswiped the yellow barrier." Former client #10 was inside the vehicle located on the passenger side. Damage to the company vehicle occurred on the passenger rear side occupied by FC #10. Incident occurred in a parking lot.	V 367		

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V 367	Continued From page 6 -07/31/19 at 5:30 PM: Staff #2 had three clients loaded on the company vehicle headed towards an outing. He backed the facility's van into another employee's car. The company vehicle hit the employee's car on the driver's side which resulted in damage to the employee's car. During interview on 10/29/19, the Program Director reported: -He had been told by prior management years ago, the agency was not required to report incidents using IRIS. The agency did not contract with the Local Management Entity nor did the agency receive Medicaid funding for clients in the program. During interview on 10/30/19, the Regional Quality Director reported: -Each states's requirements were different. In other states, the agency would be required to submit incident reports to a system similiar to IRIS. In North Carolina, the agency did not report occurrences to the t entity.	V 367		