STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on April 4, 2024. The complaint was unsubstantiated (Intake #NC00213587). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately record medications after administration for 3 of 3 clients (#1, #2 & #3), and 2 of 2 staff (#1 & Qualified Professional (QP)/Licensee) failed to demonstrate competency in medication administration. The findings are: Review on 4/2/24 of client #1's record revealed: - Admitted 2/16/24 - Diagnoses of Schizophrenia, Alcohol Use Disorder & Cataracts - Physician's order dated 3/21/24 for the following: - Senna 8.6 milligrams (mg) take 2 tablets (tab) by mouth (PO) at bedtime (Constipation) - Multivitamin take 1 tab PO at bedtime (Supplement) - Topiramate 100mg take 1 tab PO at bedtime (Seizures) - Risperidone 2mg take 1 tab PO at bedtime (Schizophrenia) - Trazodone 150mg take 1 tab PO at bedtime (Depression) - The above medications were listed on client #1's MARs for February 2024, March 2024, &	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 2 April 1-2, 2024 - The QP/Licensee's initials were the only initials on client #1's MARs, which indicated the QP/Licensee administered the medications on February 16-28, 2024, March 2024 & April 1-2, 2024 Review on 4/2/24 of client #2's record revealed: - Admitted 7/22/22 - Diagnoses of Hypertension, Hyperlipidemia, Vitamin D Deficiency, Dementia & Major Depressive Disorder - Physician's order dated for the following: - 5/24/23: - Omeprazole 40mg take 1 capsule (cap) PO once daily (Gastroesophageal Reflux Disease) - Vitamin D2 1000 Units (U) take 1 tab PO daily (Supplement) - Aspirin 81mg take 1 tab PO daily (Hypertension) - Docusate Sodium 100mg take 1 tab PO once daily (Constipation) - 11/27/23: - Ferrous Sulfate 325mg take 1 tab PO daily (Anemia) - 12/14/23: - Sertraline 24mg take 1 tab PO daily (Depression) - 3/20/24: - Atorvastatin 10mg take 1 tab PO every evening (Hyperlipidemia) - Finasteride 5mg take 1 tab PO once daily (Enlarged Prostate) - 3/27/24: - Lisinopril 5mg take 1 tab PO every morning (Hypertension) - The above medications were listed on client #2's MARs for February 2024, March 2024 & April 1-2, 2024 - The QP/Licensee's initials were the only	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 3 initials on client #2's MARs, which indicated the QP/Licensee administered the medications for February 2024, March 2024, & April 1-2, 2024 Review on 4/2/24 of client #3's record revealed: - Admitted 9/27/23 - Diagnoses of Schizoaffective Disorder, Bipolar Type, Catatonic Associated with Schizophrenia, Anxiety, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Unspecified Neurocognitive Disorder, History of Seizure Disorder with Negative Electroencephalogram, Small Lacunar Infarct Basal Ganglia, Cortical Atrophy & Seborrheic Dermatitis - Physician's order dated for the following: - 10/9/23: - Atorvastatin 40mg take 1 tab PO daily (Hypertension) - Senna 8.6mg take 2 tab PO daily at bedtime - Wixela inhale 1 puff by inhalation three times a day (TID) (COPD) - Aspirin 81mg take 1 tab PO every morning (Hypertension) - Losartan Potassium 50mg take 1 tab PO every morning (Hypertension) - Metoprolol Tartrate 25mg take 1/2 tab PO BID (Hypertension) - Vitamin D3 take 1 tab every morning (Supplement) - 3/5/24 - Memantine 10mg take 1 tab PO every morning and at bedtime (Dementia) - Divalproex 500mg take 1 tab PO BID (Bipolar Disorder) - Olanzapine 10mg take 1 tab PO every morning and evening (Schizophrenia) - Lorazepam 1mg take 1 tab PO TID (Anxiety) - The above medications were listed on client #3's MARs for February 2024, March 2024, &	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 4 April 1-2, 2024 - The QP/Licensee's initials were the only initials on client #3's MARs, which indicated the QP/Licensee administered the medications for February 2024, March 2024, & April 1-2, 2024 Review on 4/2/24 of staff #1's personnel record revealed: - Hired October 2022 - Medication administration training certificate dated 10/14/22 Review on 4/2/24 of the QP/Licensee record revealed: - Medication administration training certificate dated 8/31/21 Interviews on 4/2/24 client #1, #2, & #3 reported: - Took their medications everyday from staff #1 and the QP/Licensee - Staff #1 gave administered the evening dose of medication Interview on 4/2/24 staff #1 reported: - Was trained in medication administration - Was responsible for administering the clients' medications - He administered the clients' evening dose of medication - Was instructed by the QP/Licensee to not sign the clients' MARs after administering the clients' medications - The QP/Licensee signed the clients' MARs when he arrived the next morning Interview on 4/2/24 the QP/Licensee reported: - Had medication administration training - He and staff #1 were responsible for administering the clients' medications - He dispensed the clients' evening dose in a	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 5 medication cup before he left the facility at 1:30pm every day - Staff #1 was responsible for administering the clients' evening medications - He signed the clients' MARs when he returned to the facility the next morning - He and staff #1 shared the same initials - Verified that the initials in the clients' MARs were his - Thought he was supposed to sign the clients' MARs since he dispensed the clients' medications	V 118		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 6 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 review and interview, the facility failed to have evidence that an allegation of abuse was investigated and failed to report the allegation of abuse to the Health Care Personnel Registry (HCPR) within 5 days. The findings are: Review on 4/2/24 of client #3's record revealed: - Admitted 9/27/23 - Diagnoses of Schizoaffective Disorder, Bipolar Type, Catatonic Associated with Schizophrenia, Anxiety, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Unspecified Neurocognitive Disorder, History of Seizure Disorder with Negative Electroencephalogram, Small Lacunar Infarct Basal Ganglia, Cortical Atrophy & Seborrheic	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 7 Dermatitis Review on 4/2/24 of Former Staff (FS) #2's personnel record revealed: - Hired 8/30/22 and separated 2/15/2024 - Title: Supervisor in charge Review on 4/2/24 of the facility's record revealed: - No documentation of an investigation completed for the alleged abuse of client #3 Review on 4/2/24 of the Incident Response Improvement System (IRIS) revealed: - No IRIS report completed for the alleged abuse of client #3 Interview on 4/2/24 client #3 reported: - FS #2 "kicked me in my butt" - Could not recall when FS #2 kicked him, but it was a "few months ago" - Reported the incident to the Qualified Professional (QP)/Licensee - The QP/Licensee "fired her (FS #2)" for kicking him Interview on 4/4/24 FS #2 reported: - She never kicked or pushed client #2 - Never witnessed or heard of staff kicking or pushing any client in the facility Interview on 4/2/24 the QP/Licensee reported: - Hadn't received any complaints of client #3 being kicked in the butt - Client #3 "complained that [FS #2] pushed him...a few months back" - Investigated client #3's "complaint" of being pushed by FS #2 - Spoke with the clients and staff in the facility but no one corroborated client #3's story - "Don't believe [FS #2] pushed him"	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 8 - FS #2 wasn't terminated from the facility, she resigned for "a better job opportunity" - Didn't document the investigation or report the allegation of abuse to the HCPR because he "don't believe the complaint"	V 132		
V 366	27G .0603 Incident Response Requirements 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. (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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 9	V 366		

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 10 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 review and interview, the facility failed to A. implement written policies governing their response to a level II incident, B. issue preliminary findings of fact to the Local Management Entities/Managed Care Organizations (LME/MCO) within 5 working days of the incident, and C. immediately notify the Department of the incident. The findings are:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 11 Review on 4/2/24 of the facility's record revealed: - Incident reporting policy: "All incidents should be documented and analyzed as part of the provider's quality assurance and improvement processes... - No documentation of preliminary findings of fact for the following incidents: - Client #2's fall resulting in a head laceration - Client #3's allegation of abuse - No documentation the LME/MCO was notified of the level II incidents - No documentation the Department was notified of the level II incidents Interviews on 4/2/24 and 4/3/24 the Qualified Professional/Licensee reported: - Client #3 "complained that [FS #2] pushed him...a few months back" - Investigated client #3's "complaint" when he was notified, but he could not recall when - Spoke with the clients and staff in the facility but no one corroborated client #3's story - "Don't believe [FS #2] pushed him" - Client #2 refused to wait for staff #1 to get his walker and he started walking outside without it - Client #2 fell which caused a laceration on his head - He transported client #2 to the hospital to receive medical treatment - Didn't document the investigation or notify client #3's Department of Social Services (DSS) guardian representative because he "don't believe the complaint" - Was responsible for documenting the investigation and notifying DSS - Was responsible for submitting preliminary findings of fact to the LME/MCO - Wasn't aware that he needed to submit the preliminary findings of fact of both level II incidents to the LME/MCO	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 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.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 13 (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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 14 (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 report all level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident affecting 2 of 3 audited clients (#2 & #3). The findings are: Review on 4/2/24 of the facility's record revealed: - Incident reporting policy: "All incidents should be documented and analyzed as part of the provider's quality assurance and improvement processes...Level II...incidents must be documented in IRIS (Incident Response Improvement System)" Review on 4/2/24 of the Incident Response Improvement System (IRIS) revealed: - No IRIS report submitted for the level II incidents for: - Client #2's fall resulting in a head laceration - Client #3's allegation of abuse A. Review on 4/2/24 of client #2's record revealed: - Admitted 7/22/22 - Diagnoses of Hypertension, Hyperlipidemia, Vitamin D Deficiency, Dementia & Major Depressive Disorder	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 15	V 367		

- A Patient Visit Information form dated 3/14/24: "You (client #2) were seen for head laceration (cut)...It (laceration) has been repaired with sutures that will need to be removed in about 5-7 days"

Interview on 4/2/24 client #2 reported:
- He fell a "couple weeks ago" walking outside and hurt his head
- Had a walker, but the was in his bedroom at the time of his fall
- He used his walker, but he "sometimes didn't feel like using it"
- The Qualified Professional/Licensee took him to the hospital
- He had to get stitches

B. Review on 4/2/24 of client #3's record revealed:
- Admitted 9/27/23
- Diagnoses of Schizoaffective Disorder, Bipolar Type, Catatonic Associated with Schizophrenia, Anxiety, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Unspecified Neurocognitive Disorder, History of Seizure Disorder with Negative Electroencephalogram, Small Lacunar Infarct Basal Ganglia, Cortical Atrophy & Seborrheic Dermatitis

Interview on 4/2/24 client #3 reported:
- FS #2 "kicked me in my butt"
- Could not recall when FS #2 kicked him
- Reported the incident to the Qualified Professional (QP)/Licensee
- The QP/Licensee "fired her" for kicking him

Interviews on 4/2/24 and 4/3/24 the QP/Licensee reported:
- Client #3 "complained that [FS #2] pushed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-075	A. BUILDING: _____ B. WING _____	R-C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AJINNDA 13 GROUP LIVING FACILITY, LLC	408 WEST MOREHEAD STREET ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 16 him...a few months back" - Investigated client #3's "complaint" when he was notified, but he could not recall when - Spoke with the clients and staff in the facility but no one corroborated client #3's story - "Don't believe [FS #2] pushed him" - Didn't document the investigation because he "don't believe the complaint" - Client #2 refused to wait for staff #1 to get his walker and he started walking outside without it - Client #2 fell which caused a laceration on his head - He transported client #2 to the hospital to receive medical treatment - Was responsible for submitting level II incidents into IRIS - Wasn't aware that he needed to submit the level II incidents into IRIS and notify the LME/MCO	V 367		