STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-139	A. BUILDING: _____ B. WING _____	12/18/2024

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NEVIN #3	3829 NEVIN ROAD CHARLOTTE, NC 28269

(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 An annual survey was completed on 12/18/24. Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. 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 (E) name or initials of person administering the drug.	V 118		

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V 118	Continued From page 1 (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 reviews and interviews, the facility failed to keep the Medication Administration Records (MARs) current, failed to record medications immediately after administration and failed to follow physician order for medication for 1 of 3 audited clients (#2). The findings are: Review on 12/12/24 of client #2's record revealed: -An admission date of 3/1/24. -Diagnoses of Attention-Deficit Hyperactivity Disorder Unspecified Type; Bipolar Disorder, Unspecified; Intellectual Disability Disorder, Mild Per External Comprehensive Clinical Assessment; Schizoaffective Disorder, Bipolar Type; Obsessive Compulsive Disorder; Avoidant/Restrictive Food Intake Disorder. -Physician's orders dated 8/21/24 for Abilify Maintena (schizophrenia)-400mg (milligrams) syringe with the following instructions, "Inject 400mg intramuscularly every 3 weeks (given by nursing)." Review on 12/12/24 of client #2's September, October, and November 2024 physical MARs revealed: -"Not given at facility 11:00 am."	V 118	QP and Nursing Staff will collaborate to ensure Client #2's medicine is immediately discontinued with outside pharmacy and transferred to Tarrytown, which is RHA's local pharmacy. Nursing Staff will ensure Client#2 receives her injection in a timely manner and will document in QMar immediately following the administration of Client#2's injection.	

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V 118	Continued From page 2 -Client #2's paper MARs at the facility had no documentation of the administration of Abilify injections. Review on 12/12/24 of client #2's September, October, and November 2024 MARs revealed: -"Not given at facility 11:00 am." -Paper copy of client #2's electronic MARs that was located at corporate office. -Had no documentation of administration of client #2's Abilify injections. -Was not initialed to reflect dates of administration of client #2's Abilify injections. -No documentation the Abilify was given by an outside medical provider. Review on 12/17/24 of client #2's September, October, and November 2024 MARs revealed: -"Not given at facility 11:00 am." -Paper copy of client #2's electronic MARs kept by the Facility Registered Nurse (RN). -MARs with facility RN's handwritten initials documenting Abilify was administered on 10/15/24, 11/6/24, and 12/4/24. -No documented dates the Abilify was scheduled, missed and rescheduled for client #2. Interview on 12/12/24 with the Qualified Professional (QP) revealed: -Corporate office kept electronic MARs. -Provided paper copy of client #2's electronic MARs for survey review. Interview on 12/11/24 with client #2 revealed: -Staff administered the medications. -Had never refused any of her prescribed medications. -"I know my medications...Abilify, they finally got that straight..." -Department of Social Services Legal Guardian	V 118		

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V 118	Continued From page 3 (DSS LG) "also helps make sure I am taking them (medications)..." -"Knowing my medications is one of my goals." Interview on 12/11/24 with Staff #1 revealed: -Trained to administer medication. -Onsite medications were given as prescribed with no refusals or missed medication. -Client #2's Abilify was not kept at the facility and was not documented on the MARs because it was not administered by the facility staff. -Abilify was administered by an outside medical provider. -Facility RN kept up with Abilify schedule and MARs in corporate office. -Electronic MARs were kept at the corporate office. -Staff not aware of the injection schedule for client #2. -Appointments for client #2's Abilify injections were arranged by the facility RN and the outside medical provider. -The Facility RN coordinated with the outside medical provider and kept up with client #2's injection appointments. Interview on 12/13/24 with Staff #2 revealed : -Administered medications at the facility. -Onsite medications were given as prescribed with no refusals or missed medication. -Abilify was left blank on client #2's MARs because it was not administered by the facility staff. -Abilify was administered by an outside medical provider. -Facility RN scheduled Abilify appointment and facility provided transportation. -Facility RN kept up with electronic MARs in the corporate office.	V 118		

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V 118	Continued From page 4 Interview on 12/13/24 with Staff #3 revealed: -Administered medications at the facility and updated the MARs for medications administered. - Facility RN kept up with electronic MARs in the corporate office. -Client #2's Abilify was not administered by the facility. -Abilify was administered by an outside medical provider. Interview on 12/18/24 with Staff #4 revealed: -Provided transportation to medical and other appointments. -Trained to administer medications at the facility. -Client #2's Abilify was not administered by the facility. -Abilify was administered by an outside medical provider. -Transported client #2 for injections to the outside medical provider and received next scheduled appointment from the outside medical provider. -"The nurse (facility RN) makes the appointment. As I take them (clients) to the appointment I am scheduling the next appointment." -Provided the next scheduled appointment to the Facility RN after each client's visits to an outside medical provider, "...nursing (facility RN) is pretty much up on that." -"...she (client #2) was supposed to go (injection appointment), that was a bad weather call (9/27/24); I don't recall when...it was heavy rain...so that (appointment) went back to the nurse (facility RN)." -"Whenever something like that (unable to get to an appointment) happens, the nurse (facility RN) would have arranged for the next scheduled appointment." -"She (client #2) wasn't able to go during inclement weather (9/27/24), but she went (rescheduled appointment for injection) a couple	V 118		

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V 118	Continued From page 5 of weeks ago (12/4/24) to get her injection...never missed (injections) other than inclement weather." -"When I get the appointment date (from the outside medical provider), if there is a problem then nursing (facility RN) will schedule or reschedule the next appointment." -"She (client #2) was late for the inclement weather (9/27/24) but has not had other late appointment...not to my knowledge." Further interview on 12/13/24 with the QP revealed: -Client #2's Abilify was not administered by the facility. -The facility MARs for client #2 was not updated because client #2's Abilify injections were not administered onside at the facility. -Inquiries about client #2's Abilify injections were directed to the Facility RN to be answered. -"Nursing (facility RN) department keeps up with MARs (electronic)" for client #2's Abilify. -Staff #4 scheduled appointments and provided transportation for clients to get to medical appointments. Interview on 12/17/24 with the DSS LG revealed: -"...the only concerns I've had is making sure that her (client #2's) injections (Abilify) are timely. [Client #2] has schizophrenia, and this (not getting timely injections) impacts her mental stability. When her Abilify is not in her system her mood changes. She has worked hard to not become aggressive." -Noted a correlation between client #2's late Abilify injections (September, November and December 2024) and client #2's threatening, aggressive behaviors. -"I have worked out an arrangement with [Facility RN], the RN who is now giving the injections	V 118		

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V 118	Continued From page 6 (Abilify)." -"[Client #2] was getting the injections (Abilify) at [outside Medical Provider], and she missed her injection during the storm (September, 2024)." -"I shouldn't have been the one calling (facility RN and QP) to make sure she (client #2) got those (injection) and their (facility) excuse was storm." -Client #2 was scheduled for injection (Abilify) on 9/27/24, appointment was rescheduled and administered the injection on 10/15/24 (18 days later) -"This (late injections) has happened 3 times...not sure of all 3 dates...would have to look at my notes. But the 2nd time was during the storm in September (2024)." -Had addressed her concerns with the QP and facility staff (June 2024, September 2024). -"She (client #2) had a visit with the psychiatrist and [outside medical provider] called and said she (client #2) was off schedule with getting her injection, this was last week (12/8/24-12/14/24), and that was the 3rd time." -Client #2 was scheduled for injection on 11/27/24. The appointment was rescheduled and the injection was administered on 12/4/24 (7 days later). Further interview on 12/17/24 with the QP revealed: -When asked about client #2's schedule, MARs updates, and dates of Abilify injections, was directed to the facility RN to address. -Facility RN was responsible for updating the MARs. "That (question about updating the MARs) goes to nursing (facility RN), they usually keep a schedule...she (facility RN) can tell you more about that." -Had addressed DSS LG's past concerns about timeliness of client #2's injections and the impact on client #2's mental stability.	V 118		

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V 118	Continued From page 7 -"Yes, if she's (client #2) missed them (injections) you can see a little behavior change, staff has said you might see her talking a little more to her friends...3rd party friends in her head, she might talk to them more or have an outburst more than usual...she loves to walk and may walk a little more than usual." Interview on 12/17/24 with the Facility RN revealed: -Client #2 goes to an outside medical provider for her Abilify injections, "she goes to [outside medical provider] for those injections (Abilify)." -Client #2 had not missed injections. -Client #2 was administered Abilify injection late only once (September 2024). -Kept a paper MARs to note to herself to document when client #2 had injections administered. -Electronic MARs was on updated in the computer system because client #2's Abilify was administered by an outside medical provider. -"We (facility RNs) keep track of that (MARs)...we update the MARs...we just make a note, and I'll have a MARs (paper) that I write it (injections) in, and we keep it (MARs) up here (corporate office)." -"...the house (facility) gets her (client #2) to the appointments (injections)." -"The QP will follow up with the legal guardian if there is a delay or injection is late. Not sure if the QP followed up (with the DSS LG) when it (injection) was late during the hurricane (September, 2024)." -"...if it's (injection) late we (facility RNs) would call the provider (outside medical provider) and ask him to administer it a little later. We would call the provider...the provider was called when it was late. -"...the new arrangement (for facility RN to	V 118		

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V 118	Continued From page 8 administer Abilify injections) has been set up to begin and [client #2] will be coming to the main office (corporate office) to get her injections there." -"...she (client #2) received her last injection on the 4th (12/4/24) and will receive her next injection on the 26th (12/26/24), since the 3 weeks falls on the 25th (12/25/24) and the office is closed for the holiday." -"...when she was late in September (2024), she was supposed to receive an injection on 9/27 (2024) and did not get it until 10/15 (2024,18 days later)." -Had no explanation for why it took 18 days for the rescheduled injection. -Abilify injection was given on 11/6/24, 3 weeks from 11/6/24 would be 11/27/24..."that was the week of Thanksgiving so it was scheduled the following week on 12/4 (2024), and she (client #2) will get the next one on 12/26 (2024), we'll (facility RNs) be doing it now." -"...the new arrangement has been set up to begin and [client #2] will be coming to the main office (corporate office) to get her injections (Abilify) there." -"...we've (facility RNs) never marked it (Abilify) on our MARs (electronic and paper at facility) because it is not on site with us (administered at the facility) and we are not the ones administering it (Abilify); but now that we're doing (administering) her injections, it will be documented." -"Going forward, we (facility RNs) will have [local pharmacy] discontinue the order (Abilify) and reenter the order so it will come up on our end (electronically) to document it." -"...it (documentation on MARs) will help us keep up with scheduling. I will also reach out to our DRN (Director of Registered Nurses), but we (facility RNs) will have it (documentation), so we'll	V 118		

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V 118	Continued From page 9 be able to keep up with it (documentation of client #2's injections) on our end." This deficiency constitutes a recited deficiency.	V 118		
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		

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V 366	Continued From page 10 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	V 366		

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V 366	Continued From page 11 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 interviews the facility failed to implement written policies governing their response to Level I and II incidents as required. The findings are: Review on 12/12/24 of the facility's internal incident reports 7/21/24 to 12/12/24 revealed: -No documentation that client #2 was late getting Abilify injections (9/27/24, 11/27/24).	V 366	QP will re-inservice Direct Support Supervisor and Direct Support Professionals on proper procedures and protocols on completing and submitting Levels I and II incidents. QP will review and verify incident reports are completed and submitted as required.	

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V 366	Continued From page 12	V 366		

-No documentation client #2 was scheduled for injection on 9/27/24, appointment was rescheduled and administered the injection on 10/15/24 (18 days later).
-No documentation client #2 was scheduled for injection on 11/27/24, appointment was rescheduled and administered the injection on 12/4/24 (7 days later).
-No documentation of client #2's verbal threat that was directed at staff #3 (October 2024).
-No documentation of client #2's verbal threat to unknown peer (client) because they wouldn't buy her a drink from the store (12/7/24).
-There was no risk, cause, analysis completed for the above incidents.

Review on 12/12/24 and 12/17/24 of NC Incident Response Improvement System (IRIS) revealed:
-No documentation of client #2's verbal threat directed at staff #3 (October 2024),
-No documentation of client #2's verbal threat to an unknown client because the unknown client wouldn't buy client #2 a drink from the store (12/7/24).

Interview on 12/11/24 with Staff #1 revealed:
-Direct Support Supervisor.
-All incident reports were available at the corporate office.
-Client #2 was getting medications as prescribed.
-Did not observe changes in client #2's behavior.
-"I don't work in the home (facility) daily, all of then (clients) have hygiene, cooking and med goals ..."
-Incidents are documented in an electronic health record system.
-" ...staff that witness incident complete a level I report in [electronic health record system] ...document in [electronic health record system] for all levels, but [Qualified Professional-QP] does

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NEVIN #3	3829 NEVIN ROAD CHARLOTTE, NC 28269

(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 13 IRIS, MCO (Managed Care Organization), HCPR (Health Care Personnel Registry), and internal investigation." -No incidents related to client #2 in the past 3 months (September, October, November). -[QP] does that (was person responsible for reporting incidents in IRIS)." Interview on 12/13/24 with Staff #2 revealed: -Direct Support Professional. -Trained to administer and document medications. -Did no observe changes in client #2's behavior. -Client #2 was getting medications as prescribed. -No incident reports for client #2 in the past 3 months (September, October, November). Interview on 12/13/24 with Staff #3 revealed: -Direct Support Professional ..."there to monitor ...monitor behaviors and pass out medications." -Trained to administer and document medications. -Clients were administered medications as prescribed. -Did no have concerns or observe changes in client #2's behavior. -No incident reports for client #2 in the past 3 months (September, October, November). Interview on 12/17/24 with the Department of Social Services Legal Guardian (DSS LG) revealed: -Noted a correlation between late Abilify injections (September, November and December 2024) and client #2's threatening, aggressive behaviors. -[Client #2] has schizophrenia, and this (not getting timely injections) impacts her mental stability. When her Abilify is not in her system her mood changes. She has worked hard to not become aggressive."	V 366		

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V 366	Continued From page 14 -"[Client #2] was getting the injections (Abilify) at [outside Medical Provider], and she missed her injection during the storm (September, 2024)." -"I shouldn't have been the one calling (facility RN and QP) to make sure she (client #2) got those (injection) and their (facility) excuse was storm." -Client #2 was scheduled for injection (Abilify) on 9/27/24, appointment was rescheduled and administered the injection on 10/15/24 (18 days later) . -"This (late injections) has happened 3 times...not sure of all 3 dates...would have to look at my notes. But the 2nd time was during the storm in September (2024)...I have told them (facility) if it (late injections) happens again, I will call the state." -Had addressed her concerns with the QP and facility staff (June 2024, September 2024). -"She (client #2) had a visit with the psychiatrist and [outside medical provider] called and said she (client #2) was off schedule with getting her injection (Abilify), this was last week (12/8/24-12/14/24), and that was the 3rd time." -Client #2 was scheduled for injection (Abilify) on 11/27/24. The appointment was rescheduled and the injection was administered on 12/4/24 (7 days later). -"...Last week (12/8/24-12/14/24) Sara threatened either a peer (client) or the staff (unknown) and they (staff) called after hours (crisis). They were in the store, and she (client #2) had run out of money and wanted either a peer or staff to buy something for her and when they wouldn't she said, 'I'm going to kill you.'" -"There should be an incident report from last Saturday (12/7/24) of client threatening. [QP] called me." Further interview on 12/18/24 with the DSS LG revealed:	V 366		

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V 366	Continued From page 15 -"Did they tell you the incident (12/7/24) where she threatened someone?...that was in December (2024). I can send you a copy of the afterhours email." -"...prior to her (client #2) getting her medication on 12/4/24, I had been getting calls (from QP and facility staff) about [client #2]'s behavior and we had a meeting (treatment team meeting) with her (client #2) on 12/5/24. I could see the behaviors (aggression, threatening)...When the medication (Abilify) goes out of her system, she will begin having behaviors ...without that medication (Abilify) she will hurt you...when off that med she likes to fight. I don't want to see that side and they don't want to experience that either. -"... it bothers me if they're (facility) not going to document (do incident reports). If they're (facility) going to call me, I document, and they need to document." -"She (client #2) had her last dosage (Abilify) on 12/4/24...but it (injection) was late. I don't know when she was supposed to have it, but I was able to tell because of [client #2]'s behavior...and I knew something wasn't right." -"In October (2024, date unknown), [client #2] threatened staff (#3 was pregnant)...(client #2) told me that she would 'cut the baby out." -"...there are incidents (behaviors) that are occurring and they're (facility) just not taking it serious. If they don't take her mental illness seriously, it puts her in jeopardy." Interview on 12/17/24 with the facility's Registered Nurse (RN) revealed: -Client #2 had never missed an injection of Abilify. -Client #2 was only late once in September (9/27/24) because of inclement weather. -"The QP will follow up with the legal guardian if there is a delay or injection is late. Not sure if the QP followed up (with the DSS LG) when it was	V 366		

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V 366	Continued From page 16	V 366		

late during the hurricane (September, 2024)."
-"...if it's (injection) late we (facility RNs) would call the provider (cutside medical provider) and ask him to administer it a little later. We would call the provider ...the provider was called when it was late.
-"...the new arrangement (for facility RN to administer Abilify injections) has been set up to begin and [client #2] will be coming to the main office (corporate office) to get her injections there."
-"...we've (facility RNs) never marked it (Abilify) on our MARs (electronic and paper) because it is not on site with us (administered at the facility) and we are not the ones administering it (Abilify); but now that we're doing her (client #2) injections (Abilify), it will be documented."
-"Going forward, we (facility RNs) will have [local pharmacy] discontinue the order (Abilify) and reenter the order so it will come up on our end (electronically) to document it."
-"...it (documentation on MARs) will help us keep up with scheduling. I will also reach out to our DRN (Director of Registered Nurses), but we will have it (documentation), so we'll be able to keep up with it (documentation of client #2's Abilify injections) on our end."

Interview on 12/17/24 and 12/18/24 with the QP revealed:
-Responsible for reporting incidents in IRIS.
-When asked about client #2's injection schedule, MARs updates, and dates of Abilify injections was directed to the facility RN to address..."That's a nursing question."
-The facility RN was the person responsible for updating the MARs for the Abilify injections, "That goes to nursing (facility RN). They (facility RNs) usually keep a schedule...she (facility RN) can tell you more about that."

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V 366	Continued From page 17 -The facility RN kept appointments for client #2's injections and should address questions about client #2's late injections. -"Staff accompanies client #2 (to appointments), more than likely [Staff #4]; staff is definitely in there (with outside medical provider) to make sure the right things are said (information is reported)." -Had provided all incident reports for the past 3 months. -Did not recall and had no documentation for behavior incidents reported by DSS LG. -Did not document or recall making a report regarding client #2's threat to unknown peer (client) on 12/7/24. -Had noticed behavior changes in client #2 when Abilify injections were late, "yes, if she's (client #2) missed them (injections) you can see a little behavior change; staff has said you might see her talking a little more to her 'friends', 3rd party friends in her head. She might talk more or have an outburst more than usual. She loves to walk and my walk more than usual." -Failed to document attending to the health and safety need of individuals involved in incidents. -Had not written and submitted findings to the local Management Entity/Managed Care Organization in the required timeframe.	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	V 367		

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V 367	Continued From page 18 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. (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	V 367		

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V 367	Continued From page 19 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 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to submit Level II incidents reports to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 12/12/24 of the Facility's Internal Incident reports 7/21/24 to 12/18/24 revealed: -No documentation that client #2 was late getting Abilify injections (9/27/24, 11/27/24). -No documentation client #2 was scheduled for injection on 9/27/24, appointment was rescheduled and administered the injection on 10/15/24 (18 days later) -No documentation client #2 was scheduled for injection on 11/27/24, appointment was rescheduled and administered the injection on 12/4/24 (7 days later). -No documentation of client #2's verbal threat that was directed at staff #3 (October 2024). -No documentation of client #2's verbal threat to unknown peer (client) because the peer wouldn't buy client #2 a drink from the store (12/7/24). Review on 12/12/24 and 12/17/24 of NC Incident Response Improvement System (IRIS) revealed: -No documentation of client #2 verbal threat directed at staff #3 (October 2024). -No documentation of client #2 verbal threat to unknown client because the client wouldn't buy client #2 a drink from the store (12/7/24). Interview on 12/12/24 with Staff #1 revealed: -Direct Support Supervisor. -Qualified Professional (QP) was immediate supervisor. -No incidents related to client #2 in the past 3 months (September, October, November 2024).	V 367	QP will submit Level II Incident Reports into the NC Incident Response Improvement System (IRIS) and Local Managementt Entity/Managed Care Organization (LME/MCO)based on the service definition in a timely manner.	

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V 367	Continued From page 21 -"...[QP] does IRIS, MCO (Managed Care Organization), HCPR (Health Care Personnel Registry), and internal investigation." -QP was person responsible for reporting incidents in IRIS, "[QP] does that." Interview on 12/17/24 with the Department of Social Services Legal Guardian (DSS LG) revealed: -Noted a correlation between late Abilify injections (September, November and December 2024) and client #2's threatening, aggressive behaviors. -"[Client #2] has schizophrenia, and this (not getting timely injections) impacts her mental stability. When her Abilify is not in her system her mood changes. She has worked hard to not become aggressive." -"[Client #2] was getting the injections (Abilify) at [outside Medical Provider], and she missed her injection during the storm (September, 2024)." -"I shouldn't have been the one calling (facility RN and QP) to make sure she (client #2) got those (injection) and their (facility) excuse was storm." -Client #2 was scheduled for injection (Abilify) on 9/27/24, appointment was rescheduled and the injection was administered on 10/15/24 (18 days later) . -"This (late injections) has happened 3 times...not sure of all 3 dates...would have to look at my notes. But the 2nd time was during the storm in September (2024)...I have told them (facility) if it (late injections) happens again, I will call the state." -"She (client #2) had a visit with the psychiatrist and [outside medical provider] called and said she (client #2) was off schedule with getting her injection (Abilify), this was last week (12/8/24-12/14/24), and that was the 3rd time." -Client #2 was scheduled for injection (Abilify) on 11/27/24. The appointment was rescheduled	V 367		

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V 367	Continued From page 22 and the injection was administered on 12/4/24 (7 days later). -"...Last week (12/8/24-12/14/24) Sara threatened either a peer (client) or the staff (unknown) and they (staff) called after hours (crisis). They were in the store, and she (client #2) had run out of money and wanted either a peer or staff to buy something for her and when they wouldn't she said, 'I'm going to kill you.'" -"There should be an incident report from last Saturday (12/7/24) of client threatening. [QP] called me." Further interview on 12/18/24 with the DSS LG revealed: -"Did they tell you the incident (12/7/24) where she threatened someone?...that was in December (2024). I can send you a copy of the afterhours email." -"...prior to her (client #2) getting her medication on 12/4/24, I had been getting calls (from QP and facility staff) about [client #2]'s behavior and we had a meeting (treatment team meeting) with her (client #2) on 12/5/24. I could see the behaviors (aggression, threatening)...When the medication (Abilify) goes out of her system, she will begin having behaviors ...without that medication (Abilify) she will hurt you...when off that med she likes to fight. I don't want to see that side and they don't want to experience that either. -"... it bothers me if they're (facility) not going to document (do incident reports). If they're (facility) going to call me, I document, and they need to document." -"She (client #2) had her last dosage (Abilify) on 12/4/24...but it (injection) was late (was scheduled for 11/27/24). I don't know when she was supposed to have it, but I was able to tell because of [client #2]'s behavior...and I knew something wasn't right."	V 367		

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V 367	Continued From page 23 -"In October (2024, date unknown), [client #2] threatened staff (#3 was pregnant)...(client #2) told me that she would 'cut the baby out." -"...there are incidents (behaviors) that are occurring and they're (facility) just not taking it serious. If they don't take her mental illness seriously, it puts her in jeopardy." Review on 12/18/24 of email from the DSS LG revealed: -Copy of email dated 12/7/24, sent to DSS LG from [County] After Hours Social Worker (AHSW) (DSS crisis reporting line) stating the following: -"AHSW received a call from [QP] [contact information] in reference to [client #2]. [QP] stated that that [client #2] asked another resident to by her a drink which they were at the store today. When the resident refused to buy [client #2] the drink, [client #2] threatened to kill the resident. Facility staff spoke with [client #2] about her threat, and she denied saying it. [Client #2] apologized to the resident and said that she didn't mean the threat if she did say it. [QP] stated she wanted to notify SW [LG] about the incident. Currently, both [client #2] and the other resident are stable and getting along with each other." Review on 12/17/24 with the Nurse revealed: -Client #2 had never missed an injection of Abilify. -Client #2 was only late once in September (9/27/24) because of inclement weather. -"The QP will follow up with the legal guardian if there is a delay or injection is late. Not sure if the QP followed up (with the DSS LG) when it was late during the hurricane (September, 2024)." -"...if it's (injection) late we (facility RNs) would call the provider (outside medical provider) and ask him to administer it a little later. We would call the provider...the provider was called when it was late	V 367		

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V 367	Continued From page 24 -"There wouldn't be an incident report, if it's (injection) late we (facility RNs) would call the provider (outside medical provider) and ask him to administer it a little later. We would call the provider...the provider was called when it (injection) was late (9/27/24). Interview on 12/17/24 and 12/18/24 with the QP revealed: -Responsible for reporting incidents in IRIS. -Did not recall if incident report was completed for client #2's missed or late Abilify injections (9/27/24, 11/27/24). -"Legal guardian should have been notified or either nursing may have contacted her...pretty sure we notified legal guardian or nursing would do that." -"...I don't think it (rescheduled injection) was too far out...when stuff like that happens we try to get it done as soon as possible; the nurse knew (was aware of rescheduled injection, 10/15/24) -Had noticed behavior changes in client #2 when Abilify injections were late, "...yes, if she's (client #2) missed them (injections) you can see a little behavior change; staff has said you might see her talking a little more to her friends, 3rd party friends in her head. She might talk more or have an outburst more than usual. She loves to walk and my walk more than usual." -Had not made any reports in IRIS and had no internal incident reports to document client #2's threats or changes in her behavior. -Had provided all incident reports. -Did not recall making a report to the AHSW (crisis reporting line) regarding client #2's threat to an unknown peer on 12/7/24. -Did not recall and had no documentation for incidents reported by DSS LG.	V 367		