STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601387	A. BUILDING: _____ B. WING _____	R 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE-SARDIS	151 NORTH SARDIS ROAD CHARLOTTE, NC 28270

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 1/31/25. The complaint was unsubstantiated (intake #NC00224198). 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 5 current clients.	V 000	RECEIVED MAR 0 3 2025 DHSR-MH Licensure Sect RECEIVED DHSR-MH Licensure Sect	
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	V 366	NeuroRestorative will develop policies to review policies in compliance with NC statutes to review all Level I, II, and III incidents and responses to all incidents that all under these levels. Following each Level I, II, III incidents a review will be completed to include cause of the incident, corrective action plans, assignment of person responsible to implement corrective action plan, and preventative measures to be taken. Program Manager to be responsible to ensure the review is completed followign each Level I, II, and III review. Preventative Measure: Each incident will be reviewed monthly by Program Manager, Program Director, and Senior QI to ensure the action plan is in place and preventative measures are in place.	3/6/25 3/6/25 3/6/25 3/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donnell Jefferson | TITLE: Operations Program Director | (X6) DATE: 2/24/2025

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V 366	Continued From page 1 (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 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	V 366		

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V 366	Continued From page 2 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 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 reviews and interviews, the	V 366		

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V 366	Continued From page 3 facility failed to implement written policies governing their responses to level I, II, or III incidents. The findings are: Review on 12/30/24 of the facility's incident reports dated 10/1/24-12/30/24 revealed: -10/8/24: Client #5 "fell out of bed during the middle of the night, when staff heard him he stated 'this doesn't happen often, but I fell out of bed' both LST (Life Skill Trainer) assisted [client #5] off the floor and transferred him back to bed. A body and head check was performed with no injuries noted." -11/6/24: Client #5 "reached for his urinal on the side of his bed, overreaching and rolled out of his bed. He was assisted up off the floor and back into bed, checked for injuries and none noted." -11/24/25: Client #2 "slid out of bed attempting to get in wheelchair. He stated his right leg gave out on him causing him to slide to the floor from his bed. Staff immediately assisted [client #2] off the floor and into his chair. Checked for injuries and none noted." -12/30/24: Client #5 "was in his wheelchair and over reached for the assistance pole in room, he fell forward out of his chair, hitting his head on the floor. Small laceration to the left eyebrow, no change in mental status, client alert and responsive. Due to nature of hitting head on ground forming a laceration, he was sent out to local ED (Emergency Department) for evaluation and imaging." Review on 12/30/24 and 1/23/30 of the facility's records from 10/1/24 to 12/30/24 revealed: -No evidence of determining cause or assigning a person for implementation of corrections and preventive measures for the incidents on 10/8/24, 11/6/24, and 12/30/24 involving client #5 and the incident on 11/24/24 involving client #2.	V 366		

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V 366	Continued From page 4 Interview on 1/23/25 with the Program Manager revealed: -Incidents are reviewed in a monthly meeting with the Senior Quality Improvement (QI) Director. -Did not have documentation of monthly review of incidents. Interview on 1/24/25 with the Registered Nurse revealed: -Did not document corrective and preventative measures for each incident or assign a person for implementation. -Incidents were reviewed by the Senior QI Director. Interview on 1/27/24 with the Senior QI Director revealed: -Did not review each incident and develop corrective and preventative measures or assign a person for implementation. -"We look at trends annually, but we don't do them (corrective and preventative measures) for each individual incident."	V 366		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities	V 513	The program monitor was removed from the program and no longer in use. Completed by the Program Manager. Privacy policies were reviewed with Program Manager and Program Nurse to ensure to participant privacy is a priority for all participants. Preventative measures: Practices were reviewed to identify that there are no other privacy concerns with any of the participants living in the home.	2/7/25 2/7/25 2/7/25

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V 513	Continued From page 5 meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to provide services using the least restrictive and most appropriate method. The findings are: Review on 1/14/25 of client #5's record revealed: -Video Monitoring Release signed by client #5"s legal guardian on 12/8/23. -"The responsible party hereby consents to the use of a video monitor by [the facility] and their staff for the purpose of preventing falls and injuries for [client #5]." Observation on 1/23/25 at 10:55am of client #5's bedroom revealed: -Camera mounted near the ceiling above client #5's bed. -The camera was pointed toward a chair on the opposite side of the room from the bed. Observation on 1/23/25 at 11:10am in the facility's living room revealed:	V 513		

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V 513	Continued From page 6 -Small monitor on top of the medication cart showing video footage of client #5"s room. -Client #5 was seen going into his room and picking up the urinal and unzipping his pants. -The Program Director turned the monitor away to provide privacy for client #5 as he urinated. Interview on 1/23/25 with client #5 revealed: -The camera was in his room in case he fell down. -"It (camera) will alert the staff ...It is great ...If I fall they will see ...It is a preventative measure." -Was not concerned about privacy. Interview on 1/23/25 with the Program Manager revealed: -The camera in client #5's bedroom was requested by client #5's family. Interview on 1/24/25 with the Registered Nurse revealed: -The camera in client #5's bedroom was due to client #5's frequent falls. -Client #5 "was having increased falls." -"He (client #5) would hide his bell and would not ask for assistance." -Talked to the family about monitoring with a camera. Interview on 1/27/25 with the Senior Quality Improvement Director revealed: -The camera in client #5's bedroom was requested by client #5's family. -Was not aware that the camera's monitor was in the living room, visible to other clients or visitors to the facility. -"We do need to take that down. We don't want anyone seeing him (client #5)."	V 513		