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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on March 31, 2025. The complaint was substantiated (intake #NC 00226783). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement treatment strategies to meet the needs of 1 of 1 audited former client (FC #3). The findings are:

Review on 3/20/25 and 3/21/25 of FC #3's record revealed:
-Date of admission: 7/3/24.
-Date of discharge: 3/3/25.
-Diagnosis of: Schizoaffective Disorder Bipolar Type.
-Comprehensive Clinical Assessment dated 2/2/24 revealed: "...medication non-compliance leading to personality disturbance, hygiene neglect, and lack of independent living skills...is a flight risk based on history..." FC #3 had been homeless and also lived independently in hotels.
-Treatment Plan dated 4/25/24 revealed: goals to " ...decrease psychotic symptoms and behaviors, improve overall physical health, anxiety and avoidance causing distress, avoidance of situations in which I think 'something bad' might occur..." There were no strategies on how to implement these goals.
-Treatment Plan dated 1/13/25 revealed: goals to "...demonstrate responsible decision-making when on his own ...name all his medications, what they are for and take medications as prescribed...with staff assistance, organize/clean

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V 112	Continued From page 2 his room...learn how to cook a simple meal with staff assistance...take responsibility for one daily chore at Riverview (facility) ...have assistance with addressing all of his medical conditions as well as assistance obtaining the appropriate medical attention...learn to access community resources as a way to find meaningful activities..." -Document entitled "Discussion Points from the Meeting" dated 1/14/25 revealed: "Team expressed concerns around health and safety for [FC #3] ...discussed the following areas: locking self in room; smoking in his room, also picking up cigarette butts from street/outside to smoke; leaving the premises with no notice and not returning for greater than 24 hours ...refusal of medication ...explosive behaviors ...resulting in the broken window ...and up continuously through out the night, disrupting peers, in and out of house (facility), turning on lights and opening doors." -Clinical Case Notes from 1/10/25 through 3/3/25 revealed: 1/10/25: smoked inside the facility, damaged property by drawing on the walls, kept other clients up throughout the night with loud noises associated with agitation; 1/30/25: threatened harm to staff; 2/11/25: threatened harm to staff; 2/27/25: verbal and physical aggression, shoved staff and hit her with an open hand, found a screwdriver (location unknown) and threatened to harm staff; 3/3/25: immediate discharge from the facility "...due to recent and reoccurring safety concerns. [FC #3's] erratic and unpredictable behavior that he has demonstrated for months and recent physical aggression towards staff, threatening with a screwdriver and sending out Riverview home address to 20+ (plus) people via text." -No treatment strategies to address continuous refusal of medications, refusal of medical care, urinating on facility walls and floors, storing urine	V 112		

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in bottles and threatening to throw urine on others, yelling and threatening others, absence without leave (AWOL), damaging property, smoking cigarettes and marijuana inside the facility, and stealing from other clients.

Review on 3/20/25 of FC #3's undated "Safety Protocol" provided by the Intellectual Developmental Disabilities (IDD) Regional Director of Operations revealed:
-The protocol only included the following list of 5 tasks staff were to complete:
"1. Contact the Crisis Line [phone number]
2. If no response, contact [Crisis Worker] [phone number]
3. Then call 911
4. Notify the QP (Qualified Professional) or On-Call person
5. Document."

Review on 3/20/25 of facility's Incident Reports from 1/1/25 through 2/27/25 regarding FC #3 revealed:
-1/29/25: yelled and charged aggressively toward Staff #2.
-2/11/25: cursed and threatened to damage staff vehicles, slap and jump on the Direct Support Supervisor (DSS) while using racial slurs.
-2/27/25: used racial slurs and profanity and grabbed a screwdriver from his room and acted as if he wanted to harm someone; pushed staff and hit her in the face with a door he slammed shut; verbally harassed the DSS.

Interviews on 3/18/25 and 3/26/25 with Client #1 revealed:
-FC #3 "needs to be supervised more...he wouldn't sleep, steal from me daily, collected a week or two weeks of urine and then urinated on the ground, he would leave puddles of it on the

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V 112	Continued From page 4 floor in the bathroom...threatened staff by saying, 'I'm going to get you and you'll never know when it's coming'...he disappeared (AWOL) for days...he was always causing problems ..." Interview on 3/18/25 with Client #2 revealed: -FC #3 "would get into confrontations with people...would go to the bathroom and after he would be in there, there would be brown stuff all over the toilet...he would pee on the bathroom floors and sometimes in his bed...he broke his own bedroom window to get back in the facility...he smoked in his room...he would come out and you could smell weed (marijuana), he set off the fire alarm and they (fire department) came out and said, 'I don't know what your policy is on drugs but you can smell it (marijuana) all over the house (facility)'...he was just not good for this place (facility) ...I guess they (Licensee) had to go through a process to get him out ..." Attempted interview with FC #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to attempt an interview. Interview on 3/18/25 with Staff #1 revealed: -FC #3 "...was very pushy...one minute he was okay, next minute he was shouting ...threatening to hurt himself...he would be gone for days...had to call the police...he would refuse to take his meds (medications), he had poor hygiene, was not clean...he would wet the bed ...was nasty and very rude with staff, accusatory, things going missing...heard he broke his window." -Had no knowledge of FC #3's treatment goals or strategies.	V 112		

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V 112	Continued From page 5 Interview on 3/19/25 with Staff #2 revealed: -There were "always issues" with FC #3. -"He (FC #3) put that house (facility) in a lot of danger." -FC #3 would "go AWOL...would always venture off and wouldn't tell anyone he was leaving, he had random people coming to the facility, posting the facility address on different dating sites...was in fear for clients and other staff...he was very non-complaint ...refused appointments...he was combative, lunged towards me...smoked weed (marijuana) in his room and the fire department was called...seemed very manic ...literally screaming in the house (facility)...went to buy a new mattress for him (FC #3) because his mattress was drenched in urine ...he would urinate on the floor in the bedroom, splashes on the wall, stains on the floor...draw on his bedroom walls, leave puddles of urine in the bathroom, leave feces on the bathroom toilet..." -Had no knowledge of FC #3's treatment goals or strategies. Interview on 3/18/25 with the DSS revealed: -FC #3 was the "only person (client) had a problem with...he was smoking pot (marijuana) in his room...was non-compliant, refused to go to any appointments...would take markers and write all over the walls in his bedroom...would keep a jug of urine in his room and said he would throw it at us (staff) if we came in his room ...would lay in urine ...picking up cigarette butts...stealing from another client...would leave for days ...he created a text thread with random people and gave out facility address...he was so agitated and wanted to come towards me, he shoved another staff, and hit her with the door...he had a screwdriver in his room...he was refusing his medications ...every day would be something going on with [FC #3] ..."	V 112		

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V 112	Continued From page 6 -Had no knowledge of FC #3's treatment goals or strategies. Interview on 3/25/25 with the Clinical Systems Analyst/Qualified Professional (QP) revealed: -When a client was admitted to facility, they "have those set goals (identified in the 4/25/24 treatment plan), because they are new to us and we are new to them. We just want to support them living in Riverview (facility)." -The goals and treatment strategies were "person specific as time passes and updates (to the treatment plan) are done." -Completed FC #3's updated treatment plan on 1/13/25, but the plan did not address FC #3's behaviors "because the behavior health team (RHA (Licensee) Crisis Team) would need to be involved" and they were not involved. The 1/13/25 treatment plan revisions were completed to "authorize services...this wasn't a full treatment team meeting, it (treatment plan) was updated for service authorization." -"Assumed" the behavioral health team would update FC #3's treatment plan strategies to address his behaviors. Interviews on 3/19/25 and 3/25/25 with the IDD Regional Director of Operations revealed: -3/19/25: Had staff turnover in Administrators and the QP since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Acknowledged FC #3 had challenging behaviors. -Acknowledged that there was a marijuana smell in the facility when FC #3 lived at the facility and that FC #3's smoking set off the fire alarm system which resulted in the local fire department's response to the facility.	V 112		

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V 112	Continued From page 7 -Acknowledged that FC #3 would urinate and store his urine in jugs or empty soda bottles and threatened to throw it at others when he was upset. -Was informed that the facility would be removed from her caseload and transferred to the mental health division with the Licensee to provide further oversight. -3/25/25: Referred surveyor to the Clinical Systems Analyst/QP regarding updates to FC #3's treatment plan. Review on 3/28/25 of the Plan of Protection (POP) signed and dated 3/27/25 by the IDD Regional Director of Operations revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? I. [FC #3] was discharged from the Riverview home (facility) on 3/3/25 due to being an imminent threat to health and safety. II. All Riverview Staff Members will be re-inserviced by IDT (Interdisciplinary Team) on Treatment Plans and documentation of goals in [electronic medical record] within 24 hours. III. Within the next 24 hours the IDT Team review with people supported who to contact if feeling unsafe, Emergency to call 911 and ensure QP/Administrator contact information listed in plain view. IV. QP to complete Health and Safety Assessments of the RV (Riverview) home within the next 24 hours. Plan of correction will be established to address ongoing monitoring in this area. Describe your plans to make sure the above happens. Executive Leadership will meet to review and evaluate the Resident Agreement for Admissions and Discharges at Riverview home. IDT will	V 112		

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V 112	Continued From page 8 provide Increased monitoring in home 2x weekly next 30 days." Review on 3/31/25 of an addendum to the POP signed and dated 3/31/25 by the IDD Regional Director of Operations revealed: " ...II ...re-inserviced on Treatment Plans and documentation of goals in [electronic medical record]. III. IDT Team to review ... IV ....within 24 hours ensuring safety of people supported and reviewing service documentation ..." Executive Leadership will meet within 30 days ...During this evaluation process we will determine how the Resident Agreement will tie back to dealing with excessive behaviors, discharge requirements/notifications and ensure health and safety of all residents if violations of the agreement occur ..." Review on 3/31/25 of a second addendum to the POP signed and dated 3/31/25 by the IDD Regional Director of Operations revealed: "V. The facility will ensure the team follows "Code Safety" protocols to ensure people supported are safe in the home in an event of a behavioral incident. VI. All People Supported Crisis Plans in the Riverview home will be reviewed and/or developed as applicable. All People supported plans will be reviewed to ensure it is adequately addressing their needs and behaviors in the event of a crisis in the home. Support Staff at Riverview Home will be re-trained by QP on current crisis plans by Friday 4/4/24. Executive Leadership will meet ...by April 4th. The updated agreement will be submitted to all current people residing at the Riverview home for review and signature by April 4th."	V 112		

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V 112	Continued From page 9 -Attached was an undated and unsigned "Code Safety" protocol for staff and clients to be trained upon. FC #3 had a diagnosis of Schizoaffective Disorder Bipolar Type. The facility did not develop and implement treatment strategies to address FC #3's behaviors which resulted in staff not having direction on how to address FC #3's behaviors of continuous refusal of medications, refusal of medical care, urinating on facility walls and floors, storing urine in bottles and threatening to throw urine on others, yelling and threatening others, going AWOL, damaging property, smoking cigarettes and marijuana inside the facility, and stealing from other clients. A safety protocol was not specific to FC #3's needs and was limited to contacting the Crisis Team and law enforcement for assistance which did not address FC #3's disruptive and dangerous behaviors. Although the treatment plan was updated on 1/13/25, no treatment strategies were added as this plan was only updated for billing and service authorization. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected in 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date;	V 113		

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V 113	Continued From page 10 (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure client records were maintained as	V 113		

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required affecting 2 of 2 audited current clients (#1 and #2) and 1 of 1 audited former client (FC #3). The findings are:

Review on 3/20/25 of Client #1's record revealed:
-Date of admission: 1/31/24.
-Diagnoses: Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Depression, Daytime Somnolence Hypotension, Chronic Obstructive Pulmonary Disorder, Chronic Bronchitis, Hypersensitivity Pneumonitis, History of Pericardial Effusion, Nocturnal Hypoxia, Tobacco Use Disorder, Cervical Spondylosis, Chronic Neck Pain, Pectus Excavatum Gastroesophageal Reflux Disease, Prostatitis, Urinary Frequency overnight, Psoriasis, Rhinitis, and Plantar Fasciitis.
-No signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician.

Review on 3/20/25 of Client #2's record revealed:
-Date of admission: 2/29/24.
-Diagnoses: Autism Spectrum Disorder, Attention Deficit Disorder, Anxiety Disorder, Obsessive Compulsive Disorder, Grand Mal and Petite Mal Seizures, Short-Term Memory Loss, and Chronic Degenerative Tremors.
-No signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician.

Review on 3/20/25 of FC #3's record revealed:
-Date of admission: 7/3/24.
-Date of discharge: 3/3/25.
-Diagnosis: Schizoaffective Disorder Bipolar Type.
-No signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician.

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V 113	Continued From page 12 Review on 3/20/25 of email correspondence dated 3/20/25 at 2:00pm from the Intellectual Developmental Disabilities (IDD) Regional Director of Operations to the Division of Health Service Regulation Surveyor revealed: -Consents to seek emergency care for all 3 clients was "destroyed in the flood during Hurricane Helene." -Have not completed all required consents after they were destroyed and will continue to attempt to do so for all consents. Interview on 3/19/25 with the Clinical Systems Analyst/Qualified Professional (QP) revealed: -Waited for the next treatment plan review meeting in order to complete all required consents. Interviews on 3/19/25, 3/20/25 and 3/25/25 with the IDD Regional Director of Operations revealed: -Continued to work on updating all the required consents. -Had staff turnover in Administrators and the QP since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Was informed that the facility would be removed from her caseload and transferred to the mental health division with the Licensee to provide further oversight.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan	V 114		

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V 114	Continued From page 13 and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were completed at least quarterly and repeated for each shift. The findings are: Review on 3/19/25 of the facility's fire and disaster drills from 1/1/24-3/19/25 revealed: -No disaster drills. -Third quarter (July - September), 2024: No first or third shift fire drills. -Fourth quarter (October-December), 2024: No fire drills. Interview on 3/18/25 with Client #1 revealed: -Completed fire drills but never completed disaster drills.	V 114		

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V 114	Continued From page 14 Interview on 3/18/25 with Client #2 revealed: -Completed fire drills with the last drill approximately one month ago. -Did not recall ever completing a disaster drill. Attempted interview with Former Client (FC) #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to attempt an interview. Interview on 3/21/25 with Staff #2 revealed: -Completed fire drills with the clients monthly working from a schedule which was posted on the bulletin board, but the bulletin board was removed so the schedule was no longer available to staff. -No disaster drills were completed. Interview on 3/26/25 with the Direct Support Supervisor revealed: -Some fire and disaster drill documentation was missing since the former Qualified Professional left employment several months ago. -Believed the fire and disaster drill documentation was "misplaced." Interviews on 3/19/25, 3/20/25 and 3/25/25 with the Intellectual Developmental Disabilities Regional Director of Operations revealed: -The facility had three shifts: first shift was 7am-3pm; 2nd shift was 3pm-11pm; 3rd shift was 11pm-7am. -Had staff turnover in Administrators and the Qualified Professional (QP) since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the	V 114		

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V 114	Continued From page 15 Clinical Systems Analyst/QP. -The Direct Support Supervisor was responsible for ensuring fire and disaster drills were completed.	V 114		
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. (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.	V 118		

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This Rule is not met as evidenced by:
Based on interview, record review, and observation, the facility failed to ensure MARs were kept current and medications were administered on the written order of a physician affecting 2 of 2 audited current clients (#1 and #2) and 1 of 1 audited former client (FC #3). The findings are:

Cross Reference: 10A NCAC 27G.0209 Medication Requirements (V120). Based on record review, interview, and observation, the facility failed to ensure medication was stored in a refrigerator between 36 degrees and 46 degrees Fahrenheit as required affecting 1 of 2 audited clients (#2).

Cross Reference: 10A NCAC 27G.0209 Medication Requirements (V123). Based on record review and interview, the facility failed to ensure all medications errors were immediately reported to a physician or pharmacist affecting 1 of 1 audited former client (FC #3).

Review on 3/20/25 of Client #1's record revealed:
-2/9/24 - " ...authorized to self-administer prescription medications ..." signed by the physician.
-12/5/24 physician's orders:
-Divalproex DR (delayed release) (Bipolar) 500 milligrams (mg) 1 tablet (tab) in the morning and 2 tabs at bedtime (HS).
-Famotidine (Gastroesophageal Reflux Disorder (GERD)) 20 mg 1 tab twice daily.
-Gabapentin (pain) 300 mg 2 capsules (caps) in

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the morning and 1 cap in the evening.
-Icosapent (cholesterol) 1 gram (gm) 1 cap twice daily.
-Lamotrigine (Bipolar) 150 mg 1 tab daily.
-Levothyroxine (hypothyroidism) 50 micrograms (mcg) 1 tab daily.
-Lurasidone (Bipolar) 40 mg 1 tab daily.
-Midodrine (blood pressure) 2.5 mg 1 tab twice daily.
-Montelukast (allergies)10 mg 1 tab daily.
-Risperidone (anxiety) 0.5 mg 1 tab in the evening.
-Roflumilast (Chronic Obstructive Pulmonary Disease (COPD)) 250 mcg 1 tab daily.
-Tamsulosin (prostate) 0.4 milligrams (mg) 1 cap (cap) daily.
-Tremfya Injection (Psoriasis) 100 mg/ml - inject subcutaneously every 56 days.
-Trelegy Ellipta (COPD) 200-30 doses - inhale 1 puff every day.
-Tretinoin Cream (Acne) 0.025% - apply pea sized amount every night at bedtime (HS).
-Vitamin B-12 (supplement) 1,000 mcg 3 tabs in the morning.
-Vitamin D3 (supplement) 5,000 units 1 tab daily.
-Combivent Respimat (COPD) 20-100 mcg inhale 1 puff 4 times daily.
-Fluticasone Spray (allergies) 50 mcg inhale 2 sprays in each nostril daily.
-Cyclobenzaprine (Spondylosis)10 mg 1 tab twice daily as needed (PRN).
-Ondansetron (nausea) 4 mg 1 tab twice daily PRN.
-12/27/24 physician's order:
-Varenicline (smoking cessation) 0.5 mg-1 mg starter pack; 0.5 mg 1 tab daily for 3 days, then 0.5mg 1 tab twice daily 4 days, then 1 mg 1 tab twice daily.
-1/3/25 physician's order:
-Lurasidone decreased from 40 mg to 20 mg

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V 118	Continued From page 18 daily. -1/22/25 physician's orders: -Levothyroxine decreased from 50 mcg to 25 mcg. -Gabapentin increased from 300 mg 2 caps in the morning and 1 cap in the evening (900 mg) to 600 mg 1 tab twice daily (1200 mg). -1/31/25: Discontinue Tamsulosin 0.4 mg 1 cap daily. Review on 3/21/25 of Client #1's MARs from 1/1/25 through 3/18/25 revealed: A. Medications documented as "NOT GIVEN (Administered) BY FACILITY" January 1-January 31: -Famotidine. -Gabapentin 300 mg - 2 caps am and 1 cap pm. -Icosapent. -Levothyroxine 50 mcg - 1 tab daily. -Lurasidone 20 mg - 1 tab daily. -Midodrine. -Montelukast. -Roflumilast. -Trelegy Ellipta. -Varenicline. -Vitamin B-12. -Vitamin D3. -Combivent Respimat. -Fluticasone Spray. February 1-February 28: -Famotidine. -Icosapent. -Lurasidone. -Midodrine. -Montelukast. -Roflumilast. -Trelegy Ellipta. -Varenicline.	V 118		

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V 118	Continued From page 19 -Vitamin B-12. -Vitamin D3. -Combivent Respimat. -Fluticasone Spray. March 1-March 18: -Famotidine. -Icosapent. -Lurasidone. -Midodrine. -Montelukast. -Trelegy Ellipta. -Vitamin B-12. -Vitamin D3. -Combivent Respimat. -Fluticasone Spray. B. Medications with no documentation for administration: January -Famotidine - 1/5/25 at 8:00 am and 1/26/25 at 8am. -Gabapentin 300 mg 2 caps - 1/5/25 at 8:00 am. -Icosapent - 1/5/25 at 8:00am and 1/26/25 at 8:00 am. -Levothyroxine 50 mcg - 1/5/25. -Levothyroxine 25 mcg- 1/24/25-1/26/25, and 1/28/25-1/30/25. -Lurasidone - 1/26/25. -Midodrine - 1/5/25 at 8:00 am and 1/26/25 at 8:00 am. -Montelukast - 1/15/25. -Roflumilast - 1/5/25, 1/25/25 and 1/26/25. -Trelegy Ellipta - 1/5/25 and 1/26/25. -Varenicline - 1/25/25 at 8:00 am and 1/26/25 at 8:00 pm. -Vitamin B-12 - 1/5/25 and 1/26/25. -Vitamin D3 - 1/5/25 and 1/26/25. -Combivent Respimat: -8:00 am on 1/5/25 and 1/26/25.	V 118		

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-12:00 pm on 1/2/25-1/6/25, 1/9/25-1/10/25, 1/12/25-1/14/25, and 1/24/25-1/27/25.
-4:00 pm on 1/1/25 through 1/31/25.
-8:00 pm on 1/1/25 through 1/15/25.
-Fluticasone Spray on 1/5/25, 1/25/25 and 1/26/25.

February
-Famotidine:
-8:00 am on 2/8/25, 2/10/25-2/21/25.
-8:00 pm on 2/8/25-2/20/25.
-Icosapent:
-8:00 am on 2/8/25; 2/10/25-2/21/25.
-8:00 pm on 2/8/25-2/20/25.
-Lurasidone - 2/8/25, 2/10/25-2/21/25.
-Midodrine:
-8:00 am on 2/8/25, 2/10/25 through 2/21/25.
-8:00 pm on 2/8/25-2/20/25.
-Montelukast - 2/8/25-2/20/25.
-Roflumilast - 2/8/25, 2/10/25-2/21/25.
-Trelegy Ellipta - 2/8/25, 2/10/25-2/21/25.
-Varenicline:
-8:00 am on 2/6/25-2/28/25.
-8:00 pm on 2/4/25-2/28/25.
-Vitamin B12 - 2/8/25, 2/10/25-2/21/25.
-Vitamin D3 - 2/8/25, 2/10/25-2/21/25.
-Combivent Respimat:
-8:00 am on 2/8/25, 2/10/25-2/21/25.
-12:00 pm on 2/3/25-2/4/25, 2/7/25-2/22/25, and 2/24/25-2/28/25.
-4:00 pm on 2/1/25-2/28/25.
-8:00 pm on 2/8/25-2/20/25.
-Fluticasone Spray - 2/8/25, 2/10/25-2/21/25.

March
-Famotidine:
-8:00 am on 3/8/25.
-8:00 pm on 3/10/25-3/12/25.
-Icosapent:
-8:00 am on 3/8/25.

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V 118	Continued From page 21 -8:00 pm on 3/10/25-3/12/25. -Lurasidone - 3/8/25. -Midodrine: -8:00 am on 3/8/25. -8:00 pm on 3/10/25-3/12/25. -Montelukast - 3/10/25-3/12/25. -Roflumilast - 3/8/25. -Trelegy Ellipta - 3/8/25 -Vitamin B-12 -3/8/25. -Vitamin D3 - 3/8/25. -Combivent Respimat: -8:00 am on 3/8/25. -12:00 pm on 3/3/25-3/15/25. -4:00 pm on 3/1/25-3/17/25. -8:00 pm on 3/10/25-3/12/25. -Fluticasone Spray - 3/8/25. -Varenicline: -8:00 am on 3/1/25-3/3/25. -8:00 pm on 3/1/25-3/2/25. C. Medications documented as "self-administered" for exceptions: January -1/13/25 -Midodrine. -Risperidone. -Tamsulosin. -Trelegy Ellipta. -1/25/25 -Divalproex DR. -Icosapent (8:00 am). -Lamotrigine. -Lurasidone. -Levothyroxine (decreased to 25 mcg 1/25/25). -Midodrine (8:00 am). -Gabapentin (8:00 am). -Combivent Respimat (8:00 am). -Trelegy Ellipta. -Vitamin B12. -Vitamin D3. February	V 118		

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V 118	Continued From page 22 2/7/25 -Gabapentin 600 mg (8:00 pm). -Tretinoin Cream. 2/8/25 -Divalproex DR 500 mg (8:00 am and 8:00 pm). -Gabapentin 600 mg (8:00 am and 8:00 pm). -Levothyroxine 25 mcg. -Lamotrigine. -Risperidone. -Tretinoin Cream. March -3/10/25 -Divalproex DR 500 mg (8:00 pm). -Gabapentin 600 mg (8:00 pm). -Tretinoin Cream. -Risperidone. -Varenicline (8:00 pm). -3/11/25 -Divalproex DR 500 mg (8:00 pm). -Gabapentin 600 mg (8:00 pm). -Tretinoin Cream. -Risperidone. -Varenicline (8:00 pm). -3/12/25 -Gabapentin 600 mg (8:00 pm). -Tretinoin Cream. -Risperidone. -Varenicline (8:00 pm). 3/17/25 -Divalproex DR 500 mg (8:00 am). -Gabapentin 600 mg (8:00 am). -Levothyroxine 25 mcg. -Lamotrigine. -Varenicline (8:00 am). D. PRN Medications Administered for Reasons Other Than for What it was Ordered: January -Cyclobenzaprine documented as administered for "HIGH SYSTOLIC PRESSURE" on 1/5/25, 1/6/25 x 2, 1/7/25 x 2, 1/8/25, 1/9/25 x 2, 1/10/25 x 2, 1/11/25 x 2, 1/12/25, 1/14/25, 1/15/25 x 2, 1/16/25 x 2, 1/17/25 x 2, 1/18/25 x2, 1/19/25 x 2,	V 118		

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V 118	Continued From page 23 1/20/25 x 2, 1/21/25 x 2, 1/22/25 x 2, 1/23/25 x 2, 1/24/25, 1/26/25, 1/27/25 x 2, 1/28/25 x 2, 1/29/25 x 2, 1/30/25 x 2, and 1/31/25 x 2. Documented as administered for "CHAPPED SKIN" on 1/8/25. -Ondansetron documented as administered for "HIGH SYSTOLIC PRESSURE" on 1/5/25, 1/6/25 x 2, 1/7/25, 1/8/25, 1/18/25 x2, 1/19/25 x 2, 1/20/25 x 2, 1/21/25 x 2, 1/22/25 x 2, 1/23/25 x 2, 1/24/25, 1/26/25, 1/27/25, 1/28/25 x 2, 1/29/25 x 2, 1/30/25 and 1/31/25 x 2. Documented as administered for "LOW SYSTOLIC PRESSURE" on 1/27/25. February -Cyclobenzaprine documented as administered for "HIGH SYSTOLIC PRESSURE" on 2/1/25 x 2, 2/2/25 x 2, 2/3/25 x 2, 2/4/25 x 2, 2/5/25 x 2, 2/6/25 x 2, 2/7/25, 2/21/25, 2/22/25 x 2, 2/23/25 x 2, 2/24/25, 2/25/25, 2/26/25, 2/27/25 and 2/28/25. -Ondansetron documented as administered for "HIGH SYSTOLIC PRESSURE" on 2/1/25 x 2, 2/2/25 x 2, 2/3/25 x 2, 2/4/25 x 2, 2/5/25 x 2, 2/6/25 x 2, 2/7/25, 2/21/25, 2/22/25 x 2, 2/23/25 x 2, 2/24/25, 2/26/25, 2/27/25 and 2/28/25. March -Cyclobenzaprine documented as administered for "HIGH SYSTOLIC PRESSURE" on 3/1/25 x 2, 3/2/25 x 2, 3/3/25, 3/4/25 x 2, 3/5/25 x 2, 3/6/25 x 2, 3/7/25 x 2, 3/8/25, 3/9/25 x 2, 3/13/25, 3/14/25, 3/15/25 x 2, 3/16/25 x 2 and 3/17/25. -Ondansetron documented as administered for "HIGH SYSTOLIC PRESSURE" on 3/1/25 x 2, 3/2/25 x 2, 3/3/25, 3/4/25 x 2, 3/5/25 x 2, 3/6/25 x 2, 3/7/25 x 2, 3/8/25, 3/9/25 x 2, 3/13/25, 3/14/25, 3/15/25 x 2, 3/16/25 x 2 and 3/17/25. E. Documented as "PERSON REFUSED:" January:	V 118		

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V 118	Continued From page 24 -Tamsulosin on 1/14/25-1/17/25 and 1/19/25-1/31/25. -Tretinoin Cream 1/24/25 and 1/25/25. February: -Tamsulosin (discontinued 1/31/25) 2/1/25, 2/2/25 and 2/3/25. -Tremfya Injection 2/24/25. Interviews on 3/18/25 and 3/21/25 with Client #1 revealed: -Never refused his medications. -His medications were kept locked in the office by staff. -During medication administration, staff retrieved his medications out of the locked closet and "I pop my own" medication out of the bubble packs. -The only medication he "self-administered" was his injection of Tremfya, " ...been taking that for a long time." -It took "2 weeks" for his Varenicline medication to get refilled. -Before he ran out of Varenicline and waited for it to be refilled, he was smoking only 5 cigarettes daily, but now he was back up to smoking 15 cigarettes daily. -Cyclobenzaprine was prescribed as needed for "nerve pain in my neck ...neck hurts every day ..." -Ondansetron was prescribed as needed for " ...stomach problems, I don't eat like I should ..." -3/21/25: The last time he self-administered his injection of Tremfya was "about 3 weeks ago ...at the end of February." Review on 3/20/25 of Client #2's record revealed: -2/19/25 physician's order to self-administer Dairy-Aid Lactase (lactose intolerance). -12/10/24 physician's orders: -Atomoxetine (Attention Deficit Disorder (ADD)) 40 mg 1 cap daily. -Buspirone (anxiety) 15 mg 1 cap three times	V 118		

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daily.
-Fluvoxamine (depression) 100 mg 1 tab twice daily.
-Omeprazole (GERD) 20 mg 1 cap three times weekly on Monday, Wednesday, Friday.
-Prazosin HCL (nightmares) 2 mg 1 cap at bedtime.
-Tamsulosin (prostate) 0.4 mg 1 cap daily.
-Trazodone (sleep) 100 mg 2 tabs at bedtime.
-Vitamin D3 (supplement) 2,000 International Units 1 cap daily.
-Anti-Diarrhea (diarrhea) 2 mg 2 tabs for initial dose and 1 tab for each loose stool afterwards PRN.
-Ibuprofen (pain) 200 mg 2 tabs every 4 hours PRN.
-Dairy Aid-Lactase 3000 unit 3 tabs with meals that contain lactose PRN.

Review on 3/21/25 of Client #2's MARs from 1/1/25 through 3/18/25 revealed:
A. Medications documented "NOT GIVEN (Administered) BY FACILITY"
January, February and March:
-Buspirone.
-Fluvoxamine.
-Trazodone.

B. Medications with no documentation for administration
January
-Buspirone:
-8:00 am on 1/5/25, 1/18/25-1/19/25, and 1/26/25.
-2:00 pm on 1/1/25-1/27/25.
-8:00 pm on 1/13/25, 1/17/25-1/18/25.
-Fluvoxamine:
-8:00 am on 1/5/25, 1/18/25, 1/26/25.
-8:00 pm on 1/13/25, 1/17/25-1/18/25.
-Trazodone - 1/13/25, 1/17/25 and 1/18/25.

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V 118	Continued From page 26 February -Buspirone: -8:00 am on 2/2/25, 2/8/25, and 2/16/25-2/17/25. -2:00 pm on 2/3/25-2/4/25, 2/7/25-2/14/25, 2/16/25-2/22/25, and 2/24/25-2/28/25. -8:00 pm on 2/1/25, 2/10/25, 2/15/25-2/16/25. -Fluvoxamine: -8:00 am on 2/2/25, 2/8/25, 2/16/25-2/17/25. -8:00 pm on 2/1/25, 2/10/25, 2/15/25-2/16/25. -Trazodone - 2/1/25, 2/10/25, 2/15/25-2/16/25. March -Buspirone: -8:00 am on 3/2/25-3/3/25, 3/8/25-3/9/25, and 3/15/25-3/16/25. -2:00 pm on 3/1/25-3/6/25, 3/8/25-3/13/25, and 3/15/25-3/18/25. -8:00 pm on 3/1/25-3/2/25, 3/7/25-3/8/25, 3/11/25, and 3/14/25-3/15/25. -Fluvoxamine: -8:00 am on 3/2/25-3/3/25, 3/8/25-3/9/25, and 3/15/25-3/16/25. -8:00 pm on 3/1/25-3/2/25, 3/7/25, 3/11/25, and 3/14/25-3/15/25. -Trazodone - 3/1/25-3/2/25, 3/7/25-3/8/25, 3/11/25, and 3/14/25-3/15/25. C. Medications documented as self-administered for exceptions: January 1/13/25 - Prazosin. -Vascepa. February 2/8/25 - Atomoxetine. -Tamsulosin. -Vascepa. -Vitamin D3. 2/10/25 - Prazosin. -Vascepa.	V 118		

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V 118	Continued From page 27 March 3/11/25 -Prazosin. -Vascepa. 3/12/25 -Buspirone (8:00 pm). -Prazosin. -Vascepa. D. PRN Medications Administered for Reasons Other Than for What it was Ordered: February -Anti-Diarrhea on 2/11/25 with reason administered documented as "HIGH SYSTOLIC PRESSURE." -Ibuprofen on 2/23/25 with reason administered documented as "HIGH SYSTOLIC PRESSURE." Interview on 3/18/25 with Client #2 revealed: -His medications were kept locked in the office by staff. -During medication administration, "I am able to pop (out of bubble pack) my own pills (medications)." -His "dairy pills" were kept in a locked box in his room for him to access but all other medications were maintained by staff. -Medications were always available to him when he needed them. Interviews on 3/19/25 and 3/21/25 with Staff #2 revealed: -"I guarantee you they (clients) get all their meds (medications) ...it's [medication software system] and the computer at the house (facility) that mess up. The computer freezes and I have to go back later and mark (the medication) as given (administered) ...or the bar (where the medication is listed) will be grayed out and I can't initial it (medication as administered) ..." -Client #1 had 28 days of Varenicline when it was	V 118		

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ordered, he went through a "certain provider" and it took a long time (approximately 3 weeks) to get refills.
- "I just click (select) anything (for reason why a PRN medication is administered) really. I don't know what the PRN is for ..."
-Client #1 did not refuse his Tremfya Injection on 2/24/25, he said it was too early to take it, "I believe he took it a couple of days later."

Interview on 3/19/25 with the facility's Registered Nurse (RN) with the Licensed Practical Nurse present revealed:
-"Because (a client) pops their own medications (out of the bubble pack), as far as we're (nursing) concerned, it's not self-administration."
-The notation "Not Given By Facility" on the MARs " ...is the same as self-administration ...that was why certain medications were grayed out (on the MARs)."
-The grayed out areas on the MAR were "incorrectly marked" in the software system, but this was recently rectified in the system by the LPN.
-"No one self-administered (medications) ...if self-administered, it (MAR) would always be grayed out ..."

Interviews on 3/24/25 and 3/25/25 with the RN revealed:
-The only medications that were self-administered were Client #1's Tremfya injection and Client #2's Dairy Aid.
-On 2/6/25, Client #1 refused his Tremfya, "which isn't like him."
-Client #1 self-administered his own Tremfya and "he had been doing it for a long time."
-Trained staff how to administer injections during medication administration training.
-Reviewed the MARs "continuously looking at

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V 118	Continued From page 29 missed meds (medications) ...running reports and looking at exceptions ...every 2 weeks to a month ...looking at missed meds constantly ..." -Staff were required to select a reason why a PRN medication was administered when they documented medication administration on the MARs. -Did not notice that some of the reasons documented for administration of diarrhea medication or pain medication was documented by staff as chapped skin, low systolic pressure, high systolic pressure. "That is so bizarre ...staff would have had to type that (chapped skin) in ...that is not even an option ...didn't catch that at all ..." -"Honestly, we really need to do some heavy training (regarding medication administration and monitoring)." Interview on 3/24/25 with the Chief Nursing Officer revealed: -"The way [electronic medication system] is set up you can easily look at that dashboard ...things are showing up ...missed (medications) or exceptions will show up on the dashboard every day ...Not just nursing (looking at electronic medication system) ...there are a lot of eyes on [electronic medication system] ...[electronic medication system] enables you to catch an error in real time ...it is easy to track and catch administration errors ...can clearly look at a glance if PRN (medications were administered) ...any exceptions, refused or on a home visit, if not documented (as administered) ...most of the time MARs were being reviewed daily (by nursing) ..." which was the expectation. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications	V 118		

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V 118	Continued From page 30 as ordered by the physician. Review on 3/28/25 of the Plan of Protection (POP) signed and dated 3/27/25 by the Intellectual Developmental Disabilities (IDD) Regional Director of Operations revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? I. All Clinicians and Staff members at Riverview home will be in-serviced on the Medication Refusals Policy and Process within 24 hours. II. Medication that was improperly stored was confirmed by the pharmacy to still be viable and effective despite storage outside of refrigerator. Medication is to be stored in the medication designated refrigerator from this point on, staff were made aware to follow instructions on the label. III. Medication Error reporting has been clarified, and staff have been educated on proper protocol. Staff are to call nursing to report medication refusals, staff are to complete medication refusal form to submit to nursing. Nursing will be responsible for physician notification and document storage. IV. QP to complete Medication Assessment within 24 hours. Describe your plans to make sure the above happens. IDT (Interdisciplinary Team) will ensure that the following procedures are followed via monitoring of [electronic medication system] for missed medications, exceptions and PRNs. Nursing will complete weekly medication exception reviews to ensure all refused medications were reported and documented appropriately. Nursing will complete monthly medication storage assessments in each house to ensure medication	V 118		

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are being stored correctly, in date and as prescribed.
Nursing to ensure 'reason' is listed for all PRN medications and that staff are aware of PRN medication purpose prior to administering this medication.
REFUSAL of Medications and Treatments
When a person refuses a medication, the med tech (technician) should attempt to administer medications throughout the one-hour time window and document the refusal in [electronic medication system].
After the one-hour time frame, the med tech should alert nursing on-call.
Nursing will then contact the physician regarding the refusal.
The med tech should initiate the Medication Refusal form and submit it to nursing on the next business day. Nursing will review and complete any additional documentation on the form.
Nursing will document the date and time the physician was notified of the refusals and will implement any new physician orders."

Review on 3/31/25 of an addendum to the POP signed and dated 3/31/25 by the IDD Regional Director of Operations revealed:
"II ...confirmed by the pharmacy on 3/27 ...(Cased Note attached) ....3/27 Riverview staff made aware by nursing to follow instructions on the label.
III ....clarified by nursing on 3/27 ...
IV. Nursing to complete Medication Assessment within 24 hours to ensure no expired medication are stored.
...Nursing will then contact the physician or on-call pharmacist Immediately regarding the refusal."
-Attached was the Case Note by the facility RN dated 3/27/25, training completed 3/24/25 for

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V 118	Continued From page 32 PRN Documentation attended by 3 staff, and training on Medication Refusals completed 3/24/25 attended by 3 staff. This deficiency was cited 3 times on 4/29/22, 1/27/23 and 4/3/24 (Type B). Clients served by the facility had diagnoses including Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Depression and Autism Spectrum Disorder. Client #1's MARs were not kept current in that medications were inaccurately documented as administered by the facility. There were 14 medications in January that were documented as administered by the facility, 12 medications in February and 10 medications in March. There were 117 times in January when medications were not documented as administered (blank), 296 times in February and 54 times in March. Client #1 self-administered one of his medications, however there were 15 medications in January documented as self-administered, 8 medications in February and 19 medications in March. Client #1 had 2 PRN medications he needed for pain and an upset stomach. The reasons documented as administered for other than what it was ordered for occurred 73 times in January, 45 times in February and March. Staff #2 did not know what the PRN medications were for and selected random options on the electronic medical record system. Client #1 never refused his medications, however refusal of medications were documented 19 times in January and 4 times in February. Client #2's MARs were not kept current in that there were 3 medications for January, February and March that medications were inaccurately documented as not given by the facility. Medications that were not documented as administered occurred 43 times in January, 38	V 118		

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V 118	Continued From page 33 times in February and 48 times in March. Client #2 self-administered one over-the-counter medication. However, there were 2 medications in January, 6 medications in February and 5 medications in March that were incorrectly documented as self-administered. Client #2 had 2 PRN medications that were documented 2 times in February as administered for reasons other than for what it was ordered. Client #2 had a medication for Cholesterol with clear documentation on the label, MARs, and physician's orders to refrigerate. Staff had never refrigerated the medication. Former Client #3 had routine medications for mood symptoms, and Schizophrenia/Bipolar that he would often refuse. FC #3 was to receive an injection for Schizophrenia every 4 weeks. He refused this injection in both January and February. In February, FC #3 refused his Lithium 7 days in a row. There was no documentation of notifications to the physician/pharmacist of FC #3's refusals. On the 7th day of FC #3 refusing his Lithium, 2/27/25, he was involuntarily committed due to threatening staff and displaying aggressive and erratic behaviors. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the	V 120		

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V 120	Continued From page 34 refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure medication was stored in a refrigerator between 36 degrees and 46 degrees Fahrenheit as required affecting 1 of 2 audited clients (#2). The findings are: Review on 3/20/25 of Client #2's record revealed: -Date of admission: 2/29/24. -Diagnoses: Autism Spectrum Disorder, Attention Deficit Disorder, Anxiety Disorder, Obsessive Compulsive Disorder, Grand Mal and Petite Mal Seizures, Short-Term Memory Loss, and Chronic Degenerative Tremors. -12/10/24 - physician's order for Vascepa (high triglyceride levels) 1 gram (gm) take 2 capsules (caps) twice daily - "*STORE IN REFRIGERATOR.*" Observation on 3/18/25 at 2:14pm of Client #2's medications revealed: -Vascepa with pharmacy dispensed label dated	V 120		

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V 120	Continued From page 35 2/12/25 revealed "*STORE IN REFRIGERATOR*" was stored in white plastic containers in the medication closet. Review on 3/21/25 of Client #2's Medication Administration Records (MARs) from 1/1/25 through 3/21/25 revealed: -Vascepa 1 gm take 2 caps twice daily "*STORE IN REFRIGERATOR.*" Interviews on 3/18/25 and 3/21/25 with Staff #1 revealed: -"Never" stored Client #2's Vascepa in the refrigerator. Interviews on 3/19/25 and 3/21/25 with Staff #2 revealed: -Did not store Client #2's Vascepa in the refrigerator. -Was "not aware" the label on the Vascepa box and MAR indicated to store the medication in the refrigerator. Interview on 3/19/25 with the facility's Registered Nurse (RN) with the Licensed Practical Nurse present revealed: -Client #2's Vascepa not being stored in the refrigerator resulted in the medication being "probably not effective ...will lose its potency ...obviously should be in there (refrigerator) because it says so and it should have been." -Acknowledged the MAR and the physician's order indicated the medication needed to be stored in the refrigerator. Interview on 3/24/25 with a Pharmacy Representative the facility utilized for clients' medications revealed: -Vascepa was a medication that was not typically refrigerated.	V 120		

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V 120	Continued From page 36 -The medication would still be viable if it was not refrigerated and stored at room temperature. This deficiency is cross referenced into 10A NCAC 27G.0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all medications errors were immediately reported to a physician or pharmacist affecting 1 of 1 audited former client (FC #3). The findings are: Review on 3/20/25 and 3/21/25 of FC #3's record revealed: -Date of admission: 7/3/24. -Date of discharge: 3/3/25. -Diagnosis of: Schizoaffective Disorder Bipolar Type.	V 123		

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-Physician's orders:
12/3/24:
-Lithium Carbonate (Mood) 300 milligrams (mg) 1 cap twice daily.
-Risperidone (Schizophrenia) 4 mg 1 tablet (tab) at bedtime.
-Uzedy Injection (Schizophrenia) 125 mg inject intramuscularly every 4 weeks.

Review on 3/21/25 of FC #3's Medication Administration Records (MARs) from 1/1/25 through 2/27/25 revealed:
Documented as "PERSON REFUSED"
January:
-Lithium Carbonate on 1/9/25 (morning and afternoon doses), 1/10/25 (morning dose) and 1/11/25 (morning dose).
-Risperidone on 1/9/25.
-Uzedy on 1/9/25.
February:
-Lithium Carbonate on 2/21/25, 2/22/25, 2/23/25, 2/24/25, 2/25/25, 2/26/25, 2/27/25 (8:00 a.m. doses only).
-Uzedy on 2/6/25.

Review on 3/18/25 of the North Carolina Incident Response Improvement System revealed:
-Level II Incident Report involving FC #3 dated 2/27/25 revealed that FC #3 had refused his Lithium for seven days and became verbally and physically aggressive and threatened to harm staff with a screwdriver which resulted in contact to law enforcement and an involuntary commitment order.

Attempted interview with FC #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to

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V 123	Continued From page 38 attempt an interview. Interview on 3/21/25 with Staff #1 revealed: -Documented medication errors on the MAR and on shift notes. -Never notified anyone if a client refused medication. Interview on 3/21/25 with Staff #2 revealed: -When a client refused a medication, the "only protocol I know to do is contact nursing and let them know ...and document in [medication software system] 'refused' ..." Interview on 3/26/25 with the Direct Support Supervisor revealed: -Worked shifts for staff as needed. -Unable to identify the protocol of how to handle a medication refusal or error. Interview on 3/19/25 with the facility's Registered Nurse (RN) with the Licensed Practical Nurse present revealed: -When a client refused a medication, staff were to document the refusal on the MAR and notify the nursing staff and the nursing staff "kept track of it." -Notification of a medication error or refusal to the physician was "not consistently done ...with some clients, would have to do every day." -FC #3 "had a period of refusal (of medications) and staff did notify them (nursing) and we (nursing) would go out (to the facility) and try to talk to him (FC #3) and encourage him ...teaching staff to continue to try to give (administer the medication) ...ideally would have noted all the refusals ...but I don't know ..." Review on 3/19/25 of the facility Medication Error Report and Interview with the RN revealed:	V 123		

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-Received the "Medication Error Report" from her supervisor, the Chief Nursing Officer.
-Had never seen this form before, but it was used for medication refusals according to the Chief Nursing Officer.
-The form indicated a box for the type of administration error and identified "refusal to take medication" as an option.
-The form contained sections for the facility's nursing staff as well as the pharmacist/physician with signature lines.
-Nursing staff "would only know if a client refused (medication) after they went over the MARs" at the end of the month.

Interview on 3/24/25 with the Chief Nursing Officer revealed:
-Refusals of medications and medication errors were tracked for the "Board of Director Report ...we don't count as refusals because that's their (clients') right ...it's an omission, because not taking the medication ...we are tracking and monitoring that and just have nursing notes and a refusal form."
-FC #3 refused Lithium and Risperidone for several days which "can have detrimental effects ...have to make sure it's documented ...continue to offer every 15 minutes ...at that point the med (medication) tech (technician) should reach out to nursing and nursing to the physician ...especially with Lithium. Have to be very careful with that ...nursing to track refusal and make sure physician notified and if get any new orders ..."

Interview on 3/25/25 with the facility's RN revealed:
-"What we have is in the MAR" for FC #3's refusal of medication.
-For a medication error, staff would call her, and she would then "communicate with the RN of the

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V 123	Continued From page 40 RHA (Licensee) Crisis Team, and they would communicate with the doctor ...don't have documentation of this." -There was no documentation of contact to a pharmacist or physician for medication errors or refusals for Client #1 or FC #3. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by	V 290		

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V 290	Continued From page 41 the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assess the client's ability of being capable of remaining in the facility or community without supervision and update the treatment plans to identify this ability affecting 2 of 2 audited current clients and 1 of 1 audited former client (FC #3). The findings are: Review on 3/20/25 of Client #1's record revealed: -Date of admission: 1/31/24. -Diagnoses: Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Depression, Daytime Somnolence Hypotension, Chronic Obstructive Pulmonary Disorder, Chronic Bronchitis, Hypersensitivity Pneumonitis, History of	V 290		

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V 290	Continued From page 42 Pericardial Effusion, Nocturnal Hypoxia, Tobacco Use Disorder, Cervical Spondylosis, Chronic Neck Pain, Pectus Excavatum Gastroesophageal Reflux Disease, Prostatitis, Urinary Frequency overnight, Psoriasis, Rhinitis, and Plantar Fasciitis. -No assessment to determine the client's ability to remain unsupervised in the facility or community; -Treatment plan dated 10/28/24 did not identify any approved unsupervised time in the facility or the community. Review on 3/20/25 of Client #2's record revealed: -Date of admission: 2/29/24. -Diagnoses: Autism Spectrum Disorder, Attention Deficit Disorder, Anxiety Disorder, Obsessive Compulsive Disorder, Grand Mal and Petite Mal Seizures, Short-Term Memory Loss, and Chronic Degenerative Tremors. -No assessment to determine the client's ability to remain unsupervised in the facility or community; -Treatment plan dated 11/26/24 did not identify any approved unsupervised time in the facility or the community. Review on 3/20/25 of FC #3's record revealed: -Date of admission: 7/3/24. -Date of discharge: 3/3/25. -Diagnosis: Schizoaffective Disorder Bipolar Type. -Comprehensive Clinical Assessment dated 2/2/24 revealed: FC #3 had been homeless and also lived independently in hotels. -No assessment to determine the client's ability to remain unsupervised in the facility or community; -Treatment plan dated 4/25/24 and updated 1/13/25 did not identify any approved unsupervised time in the facility or the community.	V 290		

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V 290	Continued From page 43 Review on 3/20/25 of email correspondence dated 3/20/25 at 2:00pm from the Intellectual Developmental Disabilities (IDD) Regional Director of Operations to the Division of Health Service Regulation Surveyor revealed: -Unsupervised time assessments were "destroyed in the flood during Hurricane Helene." Interviews on 3/18/25 with Client #1 revealed: -Allowed to stay at the facility without staff being present, but unsure of how many hours he was allowed to stay alone. Interview on 3/18/25 with Client #2 revealed: -Allowed to stay at the facility and be in the community without staff supervision for up to 6 hours. Attempted interview with FC #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to attempt an interview. Interview on 3/19/25 with Staff #2 revealed: -All clients had 6 hours of unsupervised time. -Had worked with RHA (Licensee) since 2019 and it had "always been that way for Riverview (facility)." Interview on 3/18/25 with the Direct Support Supervisor revealed: -Was "not clear on how 6 hours of unsupervised time worked ...everyone had 6 hours ..." Interviews on 3/19/25, 3/20/25 and 3/25/25 with the IDD Regional Director of Operations revealed: -Had staff turnover in Administrators and the Qualified Professional (QP) since November	V 290		

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V 290	Continued From page 44 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Unsupervised assessments were going to be updated when the annual treatment plans were due. -Was "not aware" approved unsupervised time needed to be in the treatment plan.	V 290		
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	V 366		

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V 366	Continued From page 45 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 LME in whose catchment area the provider is located and to the LME where the client resides, if different; and	V 366		

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V 366	Continued From page 46 (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 review and interview, the facility failed to respond to Level I and II incidents. The findings are:	V 366		

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V 366	Continued From page 47 Review on 3/20/25 and 3/21/25 of Former Client (FC) #3's record revealed: -Date of admission: 7/3/24. -Date of discharge: 3/3/25. -Diagnosis of: Schizoaffective Disorder Bipolar Type. -Comprehensive Clinical Assessment dated 2/2/24 revealed: FC #3 had been homeless and also lived independently in hotels. -Clinical Case Notes from 1/10/25 through 3/3/25 revealed: 1/10/25: displayed unsafe behaviors, " ...smoking inside the home (facility), property damage, exceeding 6 hours of unsupervised time..;" 1/14/25: displayed unsafe behaviors of smoking cigarettes and marijuana, medication refusals, and extended periods of absence without leave (AWOL) and property damage; 1/30/25: displayed escalated behaviors, threatened AWOL, threatened staff which resulted in a report to law enforcement. -Document entitled "Discussion Points from the Meeting" dated 1/14/25 revealed: "Team expressed concerns around health and safety for [FC #3] ...discussed the following areas: ...smoking in his room ...leaving the premises with no notice and not returning for greater than 24 hours (Explained our (Licensee) obligations and responsibilities to ensure he is protected-Sister (legal guardian) added she did have concerns he had a fight after one of his recent leaves (AWOL), as he returned with a bloody nose and broken glasses) ...refusal of medication and inability to administer medication if he has left the premises, explosive behavior ...resulting in a the broken window ..." -Physician's orders 12/3/24: -Lithium Carbonate (Mood) 300 mg 1 cap twice daily. -Risperidone (Schizophrenia) 4 mg 1 tablet (tab) at bedtime.	V 366		

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V 366	Continued From page 48 -Uzedy Injection (Schizophrenia) 125 mg inject intramuscularly every 4 weeks. -Medication Administration Records from 1/1/25 through 2/27/25 documented as "PERSON REFUSED" January: -Lithium Carbonate on 1/9/25 (morning and afternoon doses), 1/10/25 (morning dose) and 1/11/25 (morning dose). -Risperidone on 1/9/25. -Uzedy on 1/9/25. February: -Lithium Carbonate on 2/21/25, 2/22/25, 2/23/25, 2/24/25, 2/25/25, 2/26/25, 2/27/25 (8:00 am doses only). -Uzedy on 2/6/25. Review on 3/20/25 of the facility's Incident Reports from 1/1/25 through 2/27/25 regarding FC #3 revealed: -1/29/25: "yelling at staff in a very aggressive manner..." which resulted in a report to law enforcement. -No incident reports for medication refusals. Review on 3/18/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25 through 3/18/25 revealed: -No incident reports submitted for FC #3 breaking a window, going AWOL for several days, returning from AWOL with a bloody nose and broken glasses, smoking inside the facility and setting off the fire alarm resulting in response from local emergency services, medication refusals, or for law enforcement involvement for escalated behaviors and threatening staff. Review on 3/20/25 of the facility's documents related to Incident Reports from 1/1/25 through 2/27/25 regarding FC #3 revealed:	V 366		

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V 366	Continued From page 49 -No documentation the facility attended to the health and safety needs of the individual involved, determined the cause of the incident, developed and implemented corrective measures, developed and implemented measures to prevent similar incidents, or assigned persons to be responsible for implementation of the corrections and preventative measures. Interviews on 3/18/25 and 3/26/25 with Client #1 revealed: -FC #3 "needs to be supervised more ...he would leave puddles of it (urine) on the floor in the bathroom...threatened staff...he disappeared for days ...he was always causing problems if anyone (staff/clients) was here or not..." Interview on 3/18/25 with Client #2 revealed: -FC #3 "would get into confrontations with people...he would pee (urinate) on the bathroom floors and sometimes in his bed...he broke his own bedroom window to get back in the facility...he smoked in his room...he would come out and you could smell weed (marijuana), he set off the fire alarm and they (fire department) came out and said, 'I don't know what your policy is on drugs but you can smell it (marijuana) all over the house (facility)'..." Attempted interview with Former Client (FC) #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to attempt an interview. Interviews on 3/18/25 and 3/21/25 with Staff #1 revealed: -Acknowledged incident reports were required when FC #3 went AWOL and was gone for	V 366		

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(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 50	V 366		

several days, threatened staff and destroyed property.
-Saw client bleeding, "maybe from his nose," he refused to let her look at it.
-Unable to identify how much blood or where the blood was coming from.
-Was not aware an incident report was necessary when a client refused medications or anytime the police were called.

Interviews on 3/19/25 and 3/21/25 with Staff #2 revealed:
-Acknowledged incident reports needed to be completed when FC #3 yelled and threatened staff, or anytime police were called.
-FC #3 was bleeding, " ...don't know if spitting blood or coming out of his nose ...no way to know ...bled all over the floor ...he wouldn't allow anyone to help."
-Was not aware an incident report was necessary when a client refused medications.

Interviews on 3/18/25 and 3/26/25 with the Direct Support Supervisor revealed:
-Incident reports should have been completed when FC #3 broke his window, engaged in physically aggressive behaviors, went AWOL, and urinated "all over the facility."
-Was not aware incident reports were necessary for medication refusals.

Interview on 3/19/25 with the facility's Registered Nurse (RN) with the Licensed Practical Nurse present revealed:-Was not aware incident reports needed to be completed for medication refusals.

Interview on 3/24/25 with the Chief Nursing Officer revealed:
-Refusals of medications and medication errors were tracked for the "Board of Director Report

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V 366	Continued From page 51 ...we don't count as refusals because that's their (clients') right ...it's an omission, because not taking the medication ...we are tracking and monitoring that and just have nursing notes and a refusal form." -"Depends on the type of error and what the physician says" if an incident report was completed. -FC #3 refused Lithium and Risperidone for several days which "can have detrimental effects ...have to make sure it's documented ...continue to offer every 15 minutes ...at that point the med (medication) tech (technician) should reach out to nursing and nursing to the physician ...especially with Lithium. Have to be very careful with that ...nursing to track refusal and make sure physician notified and if get any new orders ..." Interviews on 3/19/25, 3/20/25 and 3/25/25 with the Intellectual Developmental Disabilities Regional Director of Operations revealed: -Had staff turnover in Administrators and the Qualified Professional (QP) since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Acknowledged staff did not complete incident reports when necessary, regarding FC #3's challenging behaviors. -FC #3 went AWOL and was "participating in things we can't prove ...he would come back from a visit in more of a rage and his nose bleeding, smelling like alcohol and marijuana ...had a lot of bloody noses and staff trying to clean it up or call 911 and he would refuse to go ...he was refusing any medical treatment and refusing his medications."	V 366		

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V 367	Continued From page 52	V 367		
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	V 367		

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V 367	Continued From page 53	V 367		

unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet 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

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V 367	Continued From page 54 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 interview, the facility failed to report all Level II incidents to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Review on 3/20/25 of Former Client (FC) #3's record revealed: -Date of admission: 7/3/24. -Date of discharge: 3/3/25. -Diagnosis of: Schizoaffective Disorder Bipolar Type. -Comprehensive Clinical Assessment dated 2/2/24 revealed: FC #3 had been homeless and also lived independently in hotels. -Clinical Case Notes regarding FC #3 from 1/10/25 through 3/3/25 revealed: 1/10/25: displayed unsafe behaviors, " ...smoking inside the home (facility), property damage, exceeding 6 hours of unsupervised time" -1/14/25: displayed unsafe behaviors of smoking cigarettes and marijuana, and extended periods of absence without leave (AWOL) and property damage. -1/30/25: displayed behaviors, threatened AWOL, threatened staff which resulted in a report to law enforcement. -Document entitled "Discussion Points from the	V 367		

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Meeting" dated 1/14/25 revealed: "Team expressed concerns around health and safety for [FC #3] ...discussed the following areas: ...smoking in his room ...leaving the premises with no notice and not returning for greater than 24 hours (Explained our (Licensee) obligations and responsibilities to ensure he is protected-Sister (legal guardian) added she did have concerns he had a fight after one of his recent leaves (AWOL), as he returned with a bloody nose and broken glasses) ...explosive behavior ..."

Review on 3/20/25 of the facility's Incident Reports from 1/1/25 through 2/27/25 regarding FC #3 revealed:
-1/29/25: "yelling at staff in a very aggressive manner ..." which resulted in a report to law enforcement.

Review on 3/18/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25 through 3/18/25 revealed:
-No incident reports submitted for FC #3 going AWOL for several days, returning from AWOL with a bloody nose and broken glasses, smoking inside the facility and setting off the fire alarm resulting in response from local emergency services, or for law enforcement involvement for escalated behaviors and threatening staff.

Interviews on 3/18/25 and 3/26/25 with Client #1 revealed:
-FC #3 "needs to be supervised more ...he disappeared for days ..."

Interview on 3/18/25 with Client #2 revealed:
-FC #3 "would get into confrontations with people...he smoked in his room ...he would come out and you could smell weed (marijuana), he set

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V 367	Continued From page 56 off the fire alarm and they (fire department) came out and said, 'I don't know what your policy is on drugs but you can smell it (marijuana) all over the house (facility)'..." Attempted interview with Former Client (FC) #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to attempt an interview. Interviews on 3/18/25 and 3/21/25 with Staff #1 revealed: -Acknowledged incident reports were required when FC #3 went AWOL and was gone for several days, threatened staff and destroyed property. -Saw client bleeding, "maybe from his nose," he refused to let her look at it. -Unable to identify how much blood or where the blood was coming from. -Was not aware an incident report was necessary when police were called regarding a client's behavior. Interviews on 3/19/25 and 3/21/25 with Staff #2 revealed: -Acknowledged incident reports needed to be completed when FC #3 yelled and threatened staff, or anytime police were called. -FC #3 was bleeding, " ...don't know if spitting blood or coming out of his nose ...no way to know ...bled all over the floor ...he wouldn't allow anyone to help." Interviews on 3/18/25 and 3/26/25 with the Direct Support Supervisor revealed: -Incident reports should have been completed when FC #3 went AWOL.	V 367		

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V 367	Continued From page 57 Interviews on 3/19/25, 3/20/25 and 3/25/25 with the Intellectual Development Disabilities Regional Director of Operations revealed: -FC #3 went AWOL and was "participating in things we can't prove ...he would come back from a visit in more of a rage and his nose bleeding, smelling like alcohol and marijuana ...had a lot of bloody noses and staff trying to clean it up or call 911 and he would refuse to go ...he was refusing any medical treatment and refusing his medications." -Had staff turnover in Administrators and the Qualified Professional (QP) since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Acknowledged staff did not complete incident reports when necessary regarding FC #3's challenging behaviors.	V 367		
V 369	G.S. 122C-6 Smoking Prohibited § 122C-6 SMOKING PROHIBITED; PENALTY (a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, "inside" means a fully enclosed area. (b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall: (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which consists of a pictorial	V 369		

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V 369	Continued From page 58 representation of a burning cigarette enclosed in a red circle with a red bar across it. (2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product. (3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice. (c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime. (d) This section does not apply to State psychiatric hospitals. (2007-459, s. 3.) This Rule is not met as evidenced by: Based on record review and interview, the facility failed to prohibit smoking inside the facility. The findings are: Review on 3/20/25 of Client #2's record revealed: -Date of admission: 2/29/24. -Diagnoses: Autism Spectrum Disorder, Attention Deficit Disorder, Anxiety Disorder, Obsessive Compulsive Disorder, Grand Mal and Petite Mal Seizures, Short-Term Memory Loss, and Chronic Degenerative Tremors. Review on 3/20/25 of Former Client (FC) #3's record revealed: -Date of admission: 7/3/24.	V 369		

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V 369	Continued From page 59 -Date of discharge: 3/3/25. -Diagnosis: Schizoaffective Disorder Bipolar Type. -Document entitled "Discussion Points from the Meeting" dated 1/14/25 revealed: "Team expressed concerns around health and safety for [FC #3] ...discussed the following areas: ...smoking in his room ..." Interview on 3/18/25 with Client #2 revealed: -FC #3 smoked in his room. FC #3 smelled of "weed" (marijuana) when FC #3 came out of his room. -FC #3 set off the fire alarm once due to the smoke in his room. The fire department said, "I don't know what your policy is on drugs, but you can smell it (marijuana) all over the house (facility)." -Had not smelled marijuana in the facility since FC #3 was discharged. -Vaped in his bedroom with the window open. -Told all staff that he vaped in his bedroom. Attempted interview with FC #3 was unsuccessful. A telephone call to FC #3's legal guardian was made on 3/24/25 with no return call. There was no way to determine FC #3's current location and contact information to attempt an interview. Interview on 3/18/25 with Staff #1 revealed: -Denied any knowledge that clients smoked/vaped in their rooms. Interviews on 3/19/25 and 3/21/25 with Staff #2 revealed: -There were "always issues" with FC #3 and "he (FC #3) put that house (facility) in a lot of danger." -"[FC #3] smoked weed (marijuana) in his room and the fire department was called" when the	V 369		

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V 369	Continued From page 60 smoke from his room set off the fire alarm system. -Denied any knowledge that Client #2 vaped in his room. Interviews on 3/18/25 and 3/26/25 with the Direct Support Supervisor revealed: -FC #3 " ...was smoking pot (marijuana) in his room ..." -Denied any knowledge that Client #2 vaped in his room. Interviews on 3/19/25, 3/20/25 and 3/25/25 with the Intellectual Developmental Disabilities Regional Director of Operations revealed: -Had staff turnover in Administrators and the Qualified Professional (QP) since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Was not aware Client #2 vaped in his room.	V 369		
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 meaningful to the clients served/supported; and	V 513		

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V 513	Continued From page 61 (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 observation, record review, and interview, the facility failed to provide services that promoted a safe and respectful environment. The findings are: Review on 3/20/25 of Client #1's record revealed: -Date of admission: 1/31/24. -Diagnoses: Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Depression, Daytime Somnolence Hypotension, Chronic Obstructive Pulmonary Disorder, Chronic Bronchitis, Hypersensitivity Pneumonitis, History of Pericardial Effusion, Nocturnal Hypoxia, Tobacco Use Disorder, Cervical Spondylosis, Chronic Neck Pain, Pectus Excavatum Gastroesophageal Reflux Disease, Prostatitis, Urinary Frequency overnight, Psoriasis, Rhinitis, and Plantar Fasciitis. Review on 3/20/25 of Client #2's record revealed: -Date of admission: 2/29/24. -Diagnoses: Autism Spectrum Disorder, Attention Deficit Disorder, Anxiety Disorder,	V 513		

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V 513	Continued From page 62 Obsessive Compulsive Disorder, Grand Mal and Petite Mal Seizures, Short-Term Memory Loss, and Chronic Degenerative Tremors. Review on 3/20/25 of Former Client (FC) #3's record revealed: -Date of admission: 7/3/24. -Date of discharge: 3/3/25. -Diagnosis: Schizoaffective Disorder Bipolar Type. -Document entitled "Discussion Points from the Meeting" dated 1/14/25 revealed: "Team expressed concerns around health and safety for [FC #3] ...discussed the following areas: ...smoking in his room ...disrupting peers (clients)." -Clinical Case Notes from 1/10/25 through 3/3/25 revealed: 1/10/25: smoked inside the facility, damaged property by drawing on the walls, kept other clients up throughout the night with loud noises associated with agitation; 1/30/25: threatened harm to staff; 2/11/25: threatened harm to staff; 2/27/25: verbal and physical aggression, shoved staff and hit her with an open hand, found a screwdriver and threatened to harm staff; 3/3/25: immediate discharge from the facility "...due to recent and reoccurring safety concerns. [FC #3's] erratic and unpredictable behavior that he has demonstrated for months and recent physical aggression towards staff, threatening with a screwdriver and sending out Riverview (facility) home address to 20+ (plus) people via text." Review on 3/20/25 of facility's Incident Reports from 1/1/25 through 2/27/25 regarding FC #3 revealed: -1/29/25: yelled and charged aggressively toward Staff #2. -2/11/25: cursed and threatened to damage staff	V 513		

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vehicles, slap and jump on the Direct Support Supervisor (DSS) while using racial slurs.
-2/27/25: used racial slurs and profanity and grabbed a screwdriver from his room and acted if he wanted to harm someone; pushed staff and hit her in the face with a door he slammed shut; verbally harassed the DSS.

Interviews on 3/18/25 and 3/26/25 with Client #1 revealed:
-FC #3 "needs to be supervised more ...he wouldn't sleep, steal from me daily, collected a week or two weeks of urine and then urinated on the ground, he would leave puddles of it on the floor in the bathroom...he was always causing problems ...the entire time he was here was a complete stress ...like he was testing my anger threshold every day ...it was very, very frustrating ...tell staff every day and nothing happened ...I told each and every staff that was available ..."

Interview on 3/18/25 with Client #2 revealed:
-FC #3 "would get into confrontations with people...would go to the bathroom and after he would be in there, there would be brown stuff all over the toilet...he would pee (urinate) on the bathroom floors ...he smoked in his room...he would come out and you could smell weed (marijuana), he set off the fire alarm (from smoking in his room) and they (fire department) came out and said, 'I don't know what your policy is on drugs but you can smell it (marijuana) all over the house (facility)' ...he was just not good for this place ...It was stressful for me ...I was uncomfortable being around him ...so I just stayed in my room ...I was crying (to staff) from day one to get something done about it (FC #3's behaviors) ...just got a bad vibe from him ..."

Interview on 3/19/25 and 3/21/25 with Staff #2

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V 513	Continued From page 64 revealed: -There were "always issues" with FC #3. -"He (FC #3) put that house (facility) in a lot of danger." -FC #3 " ...had random people coming to facility, posting the facility address on different dating sites ...was in fear for clients and other staff ...he was combative, lunged towards me ...smoked weed (marijuana) in his room and the fire department was called" when the smoke from his room set off the fire alarm system, but was unable to provide a date of this incident. Interviews on 3/18/25 and 3/26/25 with the Direct Support Supervisor revealed: -FC #3 kept a "jug of urine" in his room and threatened to throw it at others who upset him, stole items from other clients, gave out the facility address to "random people" he texted, was verbally and physically aggressive toward others, shoved staff and threatened to harm others with a screwdriver he had in his room. -FC #3 " ...was smoking pot (marijuana) in his room ..." -"Everyday would be something" with FC #3. Interview on 3/19/25 with the Clinical Systems Analyst/Qualified Professional (QP) revealed: -Acknowledged that FC #3 displayed aggressive behaviors toward others, threatened to throw urine at others when he was agitated, went into other clients' rooms and took their personal belongings. -Had weekly house meetings with clients to discuss the importance of respecting others' belongings. Interviews on 3/19/25 and 3/25/25 with the Intellectual Developmental Disabilities (IDD) Regional Director of Operations revealed:	V 513		

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V 513	Continued From page 65 -3/19/25: Had staff turnover in Administrators and the QP since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -3/25/25: Acknowledged that there was a marijuana smell in the facility when FC #3 lived at the facility and that FC #3's smoking set off the fire alarm system which resulted in the local fire department's response to the facility. -Acknowledged that FC #3 would urinate and store his urine in jugs or empty soda bottles and threatened to throw it at others when he was upset. Review on 3/28/25 of the Plan of Protection (POP) signed and dated 3/27/25 by the IDD Regional Director of Operations revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? I. [FC #3] was discharged from Riverview home on 3/3/25 due to being an imminent threat to health and safety. II. All Riverview Staff Members will be re-inserviced by IDT (Interdisciplinary Team) on Treatment Plans and documentation of goals in [electronic medical record within 24 hours. III. Within the next 24 hours the IDT Team review with people supported who to contact if feeling unsafe, Emergency to call 911 and ensure QP/Administrator contact information listed in plain view. IV. QP to complete Health and Safety Assessments of the RV (Riverview) home within the next 24 hours. Plan of correction will be established to address ongoing monitoring in this area. V. Person Ceneterd Planning for all People Supported will be reviewed by the IDT team within	V 513		

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V 513	Continued From page 66 the next 24 hours to ensure the plans include interventions on how to respond in the event of a crisis. The team will meet to address the necessary changes and ensure support staff are trained in any changes made to the plans. Describe your plans to make sure the above happens. Executive Leadership will meet to review and evaluate the Resident Agreement for Admissions and Discharges at Riverview home. IDT will provide Increased monitoring in home 2x weekly next 30 days." Review on 3/31/25 of an addendum to the POP signed and dated 3/31/25 by the IDD Regional Director of Operations revealed: " ...Executive Leadership will meet within 30 days ...During this evaluation process we will determine how the Resident Agreement will tie back to dealing with excessive behaviors, discharge requirements/notifications and ensuring health and safety of all residents if violations of the agreement occur ...monitoring in homes 2x weekly for the next 30 days ..." Review on 3/31/25 of a second addendum to the POP signed and dated 3/31/25 by the IDD Regional Director of Operations revealed: " ...The facility will ensure the team follows "Code Safety" protocols to ensure people supported are safe in the home in an event of a behavioral incident ...Executive Leadership will meet to review and evaluate the Resident Agreement for Admissions and Discharges at Riverview home by April 4th. The updated agreement will be submitted to all current people residing at the Riverview home for review and signature by April 4th ..."	V 513		

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V 513	Continued From page 67 The facility served clients who were diagnosed with Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Depression, Autism Spectrum Disorder, Attention Deficit Disorder, and Obsessive Compulsive Disorder. FC #3 urinated on the walls and floors of common areas of the facility, stored his urine in bottles for up to two weeks and threatened to throw it at others when he was upset, damaged property, smoked in the facility, and stole items from his peers. FC #3's behaviors resulted in a living environment which was neither safe nor respectful for the other clients in the facility. As a result of FC #3's behaviors, Clients #1 and #2 identified they were stressed, frustrated, emotionally overwhelmed, and chose to self-isolate to cope with the living environment. While Clients #1 and #2 expressed their concerns to staff, nothing was done to remedy the situation until FC #3 was discharged on 3/3/25. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 513		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility and grounds were not maintained in a safe, clean, attractive and orderly manner. The findings are:	V 736		

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V 736	Continued From page 68 Observation and Interview on 3/18/25 at 3:50pm with Client #1 revealed: -In the back of the house, outside of Former Client (FC) #3's bedroom window, was an upside down 5-gallon bucket with a pile of broken glass on the bucket. -On the grass underneath the window were several pieces of broken glass, a blue piece of foam and a piece of plexiglass with tape around it. -Client #1 revealed that FC#3 had broken the window. Observation on 3/21/25 between 2:30pm and 3:20pm revealed: -Clients #1 and #2's bedroom had items which included pieces of trash, empty containers of beverages, boxes of cereal scattered all over the furniture and floor. -Both Client #1 and #2's bedrooms had a pungent, foul, and stale odor. -FC #3's bedroom had 1 large stain approximately 1 ½ feet long and 2-5 inches wide at various parts. There were 3 different shades of light and dark brown with a dark brown line along one side of the wider portion of the stain. -A second stain was a light brown circle about the size of a dime, a third stain was a dark brown shaped like a ½ moon approximately an 4 inches long and 1 inch wide. -Bottom dresser door of FC #3's bedroom had a dried light and dark brown smear of matter on the bottom of the drawer. The smear was approximately 1 ½ feet long and ½ feet wide to ½ inch wide at various parts. -The bathroom across from Client #1's bedroom had 1 large black crusty stain around and near the toilet. The stain went from the base of the toilet to the wall against the baseboard to the corner. The stain was approximately 2 ½ feet	V 736		

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long and ½ to 1 inch wide. One large black stain surrounded the base of the toilet and was ½ inch to 1 inch wide. The handrail behind the toilet had brown 3 stains on the outer portion facing the commode that were light and dark brown and appeared to be rust. The stains were approximately 3 inches to 1 inch long and ½ inch wide. The lid to the commode was off the tank and pinned behind the handrail and against the wall.
-The bathroom across from FC #3's bedroom had a black stain that surrounded the base of the toilet. The stain was approximately ½ to 1 inch wide in different areas. Behind the toilet was small white pieces of trash and 1 long brown/black stain approximately 4 inches long in the corner between the floor tile and the baseboard. The cleaning brush for the toilet was on the floor behind the toilet with the trash and brown/black stain along the baseboard.
-The kitchen floor had clear, silver and blue pieces of what appeared to be food wrapping paper, pieces of food crumbs and pieces of dirt underneath the cabinets, with some of the areas having a sticky residue.
-Four of the kitchen cabinets had light brown and black dried stains the size of dots all along the bottom door of the cabinets. The ridge at the bottom of 1 cabinet had white and black crumbs/dirt along the entire bottom approximately 2 feet long.
-The food pantry had black and brown what appeared to be food debris and hair along the baseboard at the entry of the pantry.
-The floor of the pantry had approximately 9 brown drip stains that were round approximately the size of nickels that had dried on the floor. There was also a cardboard food wrapper on the floor between the shelf and the refrigerator. Next to the food wrapper was approximately 4 stains

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V 736	Continued From page 70 that were dried and light brown approximately ½ inch wide and long. The largest stain, approximately 2 inches wide and 4 inches long, appeared to be a reddish/brownish color. Review on 3/21/25 of "Discussion Points from the Meeting" dated 1/14/25 regarding FC #3 revealed: -"Team expressed concerns around health and safety for [FC #3] ...discussed the following areas: ...explosive behavior ...resulting in the broken window..." Interview on 3/18/25 with Client #2 revealed: -FC #3 broke his own bedroom window when he wanted to get into the facility. Interviews on 3/18/25 with Staff #1 revealed: -" ...heard he (FC #3) broke his window, but I was not working then ..." Interviews on 3/19/25, 3/20/25 and 3/25/25 with the Intellectual Developmental Disabilities Regional Director of Operations revealed: -Had staff turnover in Administrators and the Qualified Professional since November 2024. -Started overseeing duties of the facility in January 2025 and had been covering as Administrator and QP with assistance from the Clinical Systems Analyst/QP. -Acknowledged FC #3 had challenging behaviors. -Was informed that the facility would be removed from her caseload and transferred to the mental health division with the Licensee to provide further oversight.	V 736		