

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS  An annual and complaint survey was completed on 04/21/2025. The complaints were unsubstantiated (Intakes #NC00227821 and #NC00229327). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.  This facility is licensed for 12 and has a current census of 7. The survey sample consisted of audits of 2 current clients and 2 former clients.	V 000	Correction:  - A training status report of all training will be supplied to Executive Leadership, HR, and Quality Department personnel to so everyone is aware of the current status of all employee training by May 14th.  - HR and Training Personnel will be trained in how to backup employee records to the network drive by May 30th  - Training will be provided to the HR, Training, and Quality Department personnel to ensure accurate tracking, monitoring, and reporting of all employee training by May 30th.	
V 108	27G .0202 (F-I) Personnel Requirements  10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108	Prevention:  - A weekly report will be sent out to HR, Quality, and Executive Leadership Team members to ensure employees are compliant with all required training courses beginning May 14th.  Monitoring:  - The Quality Director will perform quarterly audits of network drive and learning management system to ensure proper filing and backup of certificates and training transcripts.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(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 108	<p>Continued From page 1</p> <p>techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 Staff (#1 and #2) and 1 of 1 Qualified Professional (QP) had the required training to meet the MH/DD/SA needs of clients. The findings are:</p> <p>Review on 04/16/2025 of Staff #1's personnel record revealed: -Date of Hire 09/18/2023. -Job title Paraprofessional. -No evidence of MH/DD/SA training.</p> <p>Review on 04/16/2025 of Staff #2's personnel record revealed: -Date of Hire 12/16/2024. -Job title Paraprofessional. -No evidence of MH/DD/SA training.</p> <p>Review on 04/16/2025 of the QP's personnel record revealed: -Date of Hire 05/22/2023. -Job title QP. -No evidence of MH/DD/SA training.</p> <p>Interview on 04/17/2025 with Staff #1 revealed:</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(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 108	Continued From page 2  -" ... every training that I was supposed to do, I did it."  Interview on 04/21/2025 with Staff #2 revealed: -"All of my trainings are up to date."  Interview on 04/21/2025 with the Chief Agency Director revealed: -"Staff records are not kept in a centralized location where all administrative staff can access. We have the MH/DD/SA training information for all employees, but I just can not get to the records." -"So, going forward we will work closely with our IT department to ensure that Executive Leadership has the necessary access to personnel records in the absence of any employee." -"In addition, I will work with the Quality Department to ensure that our policy on Record Access is updated as well."	V 108		
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	V 366	AHS will revise and implement policies to ensure all Level I, II, and III incidents are addressed in compliance with 10A NCAC 27G .0603. The Quality Department will ensure incidents are responded to by addressing client safety, determining causes, and implementing corrective and preventive actions within 45 days. The Quality Department will oversee each response. For Level III incidents, the agency will secure client records, initiate internal reviews within 24 hours, submit preliminary findings within five business days, and issue a final report within three months. All required parties will be notified immediately. Staff training and monthly audits will ensure continued compliance.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(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 3  specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B 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:	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(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 4  (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The 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.	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(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	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level II and III incidents. The findings are:</p> <p>Reviews on 04/17/2025 and 04/21/2025 of the facility's incident reports from 01/13/2025-04/15/2025 revealed: 01/13/2025- Former Client (FC) #4's elopement, self-injury, and law enforcement involvement incident (III). 02/03/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 02/04/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 02/07/2025- An unaudited FC's physical aggression and involuntary commitment incident (III). 02/07/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 02/11/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 03/15/2025- FC #3's elopement and law enforcement involvement incident (II).</p> <p>Reviews on 04/17/2025 and 04/21/2025 of the facility's records revealed: There was no documentation to support that the above incidents had been evaluated to: -Attend to the health and safety needs of the individuals involved in the incident. -Determine the cause of the incident.</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(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 6  -Develop and implement corrective measures according to provider specified timeframes not to exceed 45 days. -Develop and implement measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days. -Assign person (s) to be responsible for implementation of the corrections and preventive measures.  Interview on 04/21/2025 with the Chief Agency Director revealed: -"We will work closely with the Quality Department to ensure that the incident response requirement is met for all incidents moving forward."	V 366		
V 367	27G .0604 Incident Reporting Requirements  10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients 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;	V 367	AHS will retrain all Residential Supervisors on proper IRIS reporting and incident notification procedures to ensure compliance with 10A NCAC 27G .0604. Moving forward, all Level II and III incidents will be submitted to the LME/MCO via IRIS within 72 hours of discovery, and any missing or requested information will be updated by the next business day. The Quality Department will be required to check IRIS 24 hours after submission for follow-up requests and respond accordingly. The Quality Department will conduct audits to ensure all incidents are reported, updated, and submitted on time.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 7  (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of 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	V 367		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 8</p> <p>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:</p> <ul style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</li> </ul> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II and III incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services as required, and failed to submit, upon request by LME/MCO other information obtained regarding the incident in IRIS. The findings are:</p> <p>Reviews on 04/17/2025 and 04/21/2025 of IRIS</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 9</p> <p>from 01/13/2025-04/15/2025 revealed: No level II or III IRIS reports or LME/MCO notifications for the following incidents: 01/13/2025- Former Client (FC) #4's elopement, self-injury, and law enforcement involvement incident (III). 02/03/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 02/04/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 02/07/2025- An unaudited FC's physical aggression and involuntary commitment incident (III). 02/07/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 02/11/2025- An unaudited FC's elopement and law enforcement involvement incident (II). 03/15/2025- FC #3's elopement and law enforcement involvement incident (II).</p> <p>Review on 04/16/2025 of FC #3's record revealed: -Admitted 01/02/2025. -Diagnosed with Post Traumatic Stress Disorder, Attention-Deficit Hyperactivity Disorder, Disruptive, Impulse Control and Conduct Disorder, and Moderate Intellectual Development Disability.</p> <p>Review on 04/21/2025 of the IRIS Report dated 04/03/2024 for FC #3 revealed: -Completed by the Residential Supervisor. -"Originally Submitted: 04/04/2025. -Date Provider Learned of Incident: 04/03/2025. -Initial Comments: LME; 04/06/2025; This IRIS report has been reviewed by MCO staff. Provider, please clarify the following info that is noted below. Once updated, please save and resubmit this IRIS report. Please resubmit within 5 days of the date of this notification. 1. This is the 2nd</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 10</p> <p>incident in which consumer was able to enter the agency vehicle; what policies/protocols were supposed to change following the incident on 4/2/25 when member stole the agency vehicle?"</p> <p>-There was no provider response as of 04/21/2025 for the above requests from the LME/MCO made on 04/06/2025.</p> <p>Interview on 04/21/2025 with the Chief Agency Director revealed:</p> <p>- "The Residential Supervisor on shift at the time of the incident was responsible for incident and IRIS reporting."</p> <p>- Was not aware that the Residential Supervisor on duty had not successfully submitted the IRIS report for the incident reports listed above with except to FC #3's incident dated 04/03/2025.</p> <p>- Was not aware that the Residential Supervisor had not responded to the LME/MCO's request for additional information for FC #3's incident dated 04/03/2025.</p> <p>- "Moving forward, the Residential Supervisors will be retrained on the incident and IRIS reporting requirements. In addition, the Residential Supervisor will be required to check IRIS 24 hours after submission to ensure that no additional information has been requested by the LME/MCO."</p>	V 367		