New BR Services Inc

506 EAST LAFAYETTE STREET

SALISBURY, NC 28144

License number MHL 080-240

PLAN OF CORRECTION

This document outlines a detailed plan of correction to address the deficiencies identified during the annual survey completed on June 19, 2025. The plan references the relevant North Carolina Administrative Code (10A NCAC 27G) rules to ensure all violations are thoroughly and accurately addressed.

An annual survey was completed on **June 19, 2025**. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 5 and has a current census of 3. The survey sample consisted of audits of 3 current clients.

10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan

Violation	Cross-Reference
The facility failed to ensure an assessment was completed for two clients (Clients #1 and #3) prior to the delivery of services.	**10A NCAC 27G .0205(a)** requires that an assessment be completed for a client, according to governing body policy, prior to the delivery of services. This assessment must include, at a minimum, the client's presenting problem, needs and strengths, a provisional or admitting diagnosis with an established diagnosis determined within 30 days, a pertinent social, family, and medical history, and appropriate evaluations.

Plan of Correction
1. Develop and Implement an Assessment Form: Immediately upon receipt of this report, the Qualified Professional (QP) and Chief Executive Officer (CEO) will develop a comprehensive **pre-admission assessment form**. This form will be designed to capture all the information required by 10A NCAC 27G .0205(a), including the client's presenting problem, needs and strengths, admitting diagnoses, and pertinent social, family, and medical history. **2. Mandatory Pre-Admission Assessment Process:** The facility's new governing body policy will require that this assessment be completed for every potential client *before* they are admitted, and services are delivered. The QP will be responsible for ensuring the assessment is fully completed, reviewed, and signed off before an admission decision is

finalized. This will involve a review of referral information and a mandatory pre-admission interview with the client, guardian, and care coordinator.

3. Corrective Action for Current Clients:

- Client #1: A comprehensive assessment, including all components of 10A NCAC 27G .0205(a), will be completed and placed in their record by August 30, 2025
- Client #3: Since Client #3 is no longer at the facility, a complete assessment will not be conducted. However, the pre-admission assessment process will be implemented for all future admissions to prevent this violation from recurring.

4. Staff Training: The CEO and QP will conduct a mandatory training session for all relevant staff by August 25, 2025, on the new pre-admission assessment policy and procedure. This training will emphasize the importance of completing this assessment prior to service delivery and the specific information required.

10A NCAC 27G .0207 Emergency Plans and Supplies

Violation	Cross-Reference
The facility failed to ensure disaster drills were held at least quarterly and repeated for each shift.	**10A NCAC 27G .0207(c)** mandates that fire and disaster drills in a 24-hour facility shall be held at least quarterly and repeated for each shift.

Plan of Correction
1. Immediate Drill Scheduling: A disaster drill will be conducted for the current quarter (July-September 2025) by September 30, 2025. This drill will be conducted under conditions that simulate a facility response to a disaster and will be completed on both the 7 am-7 pm and 7 pm-7 am shifts to ensure all staff are trained. **2. Establish a Quarterly Drill Schedule:** A written schedule for quarterly fire and disaster drills will be created for the remainder of 2025 and all of 2026. This schedule will specify the month and the shift for each drill to ensure compliance with the quarterly and multi-shift requirements. **3. Comprehensive Documentation:** A dedicated Fire and Disaster Drill Log will be implemented to accurately document all drills. The log will include: * Date and time of the drill. * Type of drill (fire or disaster). * Staff members who participated.

* The shift the drill was conducted on. * Any issues or a summary of the drill. * Signature of the person conducting the drill. **4. Staff Training:** All staff will be retrained on the importance of conducting and documenting drills in accordance with 10A NCAC 27G .0207(c). This training will be completed by August 25, 2025.

10A NCAC 27G .0209(c) Medication Requirements

Violation	Cross-Reference
The facility failed to ensure all medications were administered on a written order from an authorized prescriber and failed to ensure that Medication Administration Records (MARs) were kept current for all three audited clients.	**10A NCAC 27G .0209(c)(1)** states that prescription or non-prescription drugs shall only be administered on the written order of a person authorized by law to prescribe drugs. **10A NCAC 27G .0209(c)(4)** requires that a Medication Administration Record (MAR) of all drugs administered to each client must be kept current and that medications administered must be recorded immediately after administration.

Plan of Correction
1. Immediate Medication Reconciliation: The QP and CEO will conduct an immediate and thorough review of all current clients' medication orders against the medications actually on hand and listed on their MARs. This will be completed by August 20, 2025. Any medications without a current, written physician's order will be immediately discontinued. **2. Establish a New Pharmacy Protocol:** The facility will immediately switch to a new pharmacy that provides pre-printed MARs and medications packaged in bubble dose packs. This will minimize the risk of medications being omitted from the MARs and ensure accuracy. This new system will be in place by September 1, 2025. **3. MAR Documentation Policy:** A new policy will be implemented requiring that all medications administered be documented on the MAR *immediately* after administration, as required by the rule. This includes documenting any refusal or missed

dose, along with the reason, on the back of the MAR. The QP or CEO will review and sign off on all MARs weekly to ensure accuracy and completion.

4. Corrective Action for Identified Discrepancies:

- Client #1: The medications Fluticasone Nasal Spray and Ventolin Inhaler will not be administered unless a current, written physician's order is obtained. The MARs for April, May, and June 2025 will be corrected to reflect this.
- Client #2: The medications Chlorpromazine and Digestive Advantage Gummies will not be administered unless a current, written physician's order is obtained. The missing May 2025 MAR will be addressed by confirming the physician orders and recreating the MAR to the best of our ability with current staff and the pharmacy. The Trazodone will be added to the June MAR, and all future MARs.
- Client #3: The June MAR will be reviewed and corrected to accurately reflect medication refusals on 6/12/25 and the missed doses on 6/11/25 due to hospitalization, with a note on the back of the MAR explaining the circumstances.

5. Staff Training: All staff will receive mandatory training on the new medication administration policy and documentation requirements by August 25, 2025. The training will cover the importance of having a written order for every medication and the need for immediate, accurate documentation on the MAR.

10A NCAC 27E .0108 Client Rights - Training in Sec Rest & ITO

Violation	Cross-Reference
The facility failed to ensure staff were trained in seclusion, physical restraint, and isolation time-out.	**10A NCAC 27E .0108(b)** states that prior to providing direct care to people with disabilities whose treatment plan includes restrictive interventions, staff shall complete training in the use of seclusion, physical restraint, and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.

Plan of Correction
1. Immediate Action on Staff Training: The facility will immediately ensure that all direct care staff (Staff #1, #2, and #3, and any new hires) receive training in seclusion, physical restraint, and isolation time-out from an approved curriculum. This training will be completed for all current staff by September 30, 2025.

2. New Hire Training Policy: A new policy will be implemented to require that all new direct care staff complete this training *before* they are allowed to provide direct care. Documentation of this training, as required by 10A NCAC 27E .0108(h), will be maintained in each staff member's personnel file for at least three years.

3. Annual Refresher Training: A schedule will be established to ensure all staff receive formal refresher training at least annually to maintain their competence, as required by 10A NCAC 27E .0108(e).

4. Documentation of Restraint Use: A new policy and log will be created to document any instance where a physical restraint is used, including the date, time, duration, and reason for the restraint, and which staff were involved. This will ensure that the use of restraints is monitored and that staff are held accountable for proper implementation.

10A NCAC 27G .0303(c) Facility and Grounds Maintenance

Violation	Cross-Reference
The facility failed to be kept in a safe and attractive manner due to peeling paint in the bathroom and a broken window blind.	**10A NCAC 27G .0303(c)** requires that each facility and its grounds be maintained in a safe, clean, attractive, and orderly manner.

Plan of Correction
1. Immediate Repairs: • The peeled paint in the bathroom ceiling will be scraped, and the area will be prepped and repainted by August 30, 2025. A moisture-resistant paint will be used to prevent recurrence. • The broken window blind slats in Client #2's bedroom will be replaced with new, functional blinds by August 25, 2025. **2. Proactive Maintenance System:** A new, written Maintenance Log will be established to track all maintenance issues and repairs. This log will include the date the issue was identified, a description of the problem, the date a work order was placed, and the date the repair was completed. The CEO will be responsible for reviewing this weekly survey to ensure that all issues are addressed in a timely manner. **3. Regular Inspections:** The facility will implement a routine schedule, documented inspections of all client rooms and common areas to proactively identify and address

maintenance needs before they become a violation. These inspections will be conducted at least monthly by the CEO or a designated staff member.

This plan of correction will be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and will serve as our guide to ensure full compliance with all regulations.