Appendix 1-B: Plan of Correction Form

Plan of Correction
Please complete all requested information and email completed Plan of Correction form to: Plans.Of.Correction@dhhs.nc.gov

Provider Name:	**BLUE SAPPHIRE HOUSE**	**Phone:**	**704-214-1174**
Provider Contact Person for follow-up:	**Dr. Karen Williams** **Genita Douglas, QP**	**Fax:**	
		Email:	**aigroup14@yahoo.com**
Address:	107 W. LOUISIANA AVE. BESSEMER CITY, NC 28016		**Provider #MHL036-343**

Finding	Corrective Action Steps	Responsible Party	Timeline
Rule Violation/Tag #/Citation Level: **10A NCAC 27G .0209 MEDICATION REQUIREMENTS** **V 118 27G .0209 (C) Medication Requirements (Standard deficiency)**	**Measures to Correct:** AIG will ensure that prescription and non-prescription medications are administered to clients only upon the written order of a person legally authorized to prescribe medications. AIG will ensure that a Medication Administration Record (MAR) is maintained and kept current for each client receiving medications. All medications will be documented immediately following administration. The MAR will include, at a minimum, the following information: Client's name Name, strength, and quantity of the medication Directions for administration Date and time the medication is administered Name or initials of the staff member administering the medication **Measures to Prevent** AIG will ensure that all medication orders are obtained at intake and after each medication management or monitoring appointment. All medication orders will be filed onsite with the corresponding MAR. AIG will ensure that Medication Administration Records (MARs) for all clients are maintained onsite, kept current, and completed immediately after each medication is administered.	Clinical Director and Program Manager(s)	Implementation Date: **12-23-2025** Projected Completion Date: **12-23-2025**

	The Clinical Director provided additional staff training regarding medication administration and documentation requirements on 12/23/2025. **Who Will Monitor:** Clinical Director and Program Manager(s) **Frequency of Monitoring:** Quarterly and as needed		
10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS **V 366 27G .0603 Incident Response Requirements (Standard deficiency)**	**Measures to Correct** AIG will develop and implement written policies and procedures governing the organization's response to Level I, II, and III incidents to ensure timely, consistent, and appropriate action. **Measures to Prevent** AIG has reviewed, revised, and implemented written policies and procedures governing responses to Level I, II, and III incidents. The Clinical Director reviewed and updated the policies and provided additional staff training on the revised procedures on 12/23/2025 to ensure ongoing compliance. **Who Will Monitor:** Clinical Director and Program Manager(s) **Frequency of Monitoring:** Quarterly and as needed	Clinical Director and Program Manager(s)	Implementation Date: 12-23-2025 Projected Completion Date: 12-23-2025
10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS **V 367 27G .0604 Incident Reporting Requirements (Standard deficiency)**	**Measures to Correct** AIG will report all Level II incidents (excluding deaths) that occur during the provision of billable services or while the consumer is on the provider's premises, as well as all Level III incidents and Level II deaths involving clients to whom the provider rendered services within 90 days prior to the incident. All required incidents will be reported to the Local Management Entity (LME) responsible for the catchment area in which services are provided within 72 hours of AIG becoming aware of the incident. Reports will be submitted using the form provided by the Secretary and may be transmitted by mail, in person, facsimile, or encrypted electronic means.	Clinical Director and Program Manager(s)	Implementation Date: 12-23-2025 Projected Completion Date: 12-23-2025

	Measures to Prevent AIG will ensure ongoing compliance with incident reporting requirements by consistently reporting all Level II incidents (excluding deaths), Level III incidents, and Level II deaths within the required 72-hour timeframe to the appropriate LME using the Secretary-approved form and approved submission methods. The Clinical Director provided additional staff training on incident reporting requirements and timelines on 12/23/2025. **Who Will Monitor:** Clinical Director and Program Manager(s) **Frequency of Monitoring:** Quarterly and as needed		