Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED		
		MHL019-023	B. WING		R-C 10/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	10/00/2010	
TVAINE OF T	NOVIDEN ON OUT LIEN			NG BOULEVARD		
GRIFFIN I	HOUSE		'N LOTHER KII 'Y, NC 27344	46 BOOLEVARD		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2018. The complaint #NC00141856). The This facility is license category: 10A NCAC	as completed on October 8, was substantiated (intake re was a deficiency cited. d for the following service 27G. 5600C Adults with Developmental				
V 291	V 291 27G .5603 Supervised Living - Operations		V 291			
	six clients when the condevelopmental disabination on June 15, 2001, and than six clients at that provide services at not licensed capacity. (b) Service Coordination amaintained between the qualified professional treatment/habilitation (c) Participation of the Responsible Person. provided the opportung relationship with her command as visits to the the facility. Reports annually to the parent legally responsible per Reports may be in work conference and shall progress toward mee (d) Program Activities activity opportunities needs and the treatment activities shall be designed.	ty shall serve no more than lients have mental illness or lities. Any facility licensed d providing services to more to more than the facility's tion. Coordination shall be the facility operator and the s who are responsible for or case management. The eramily or Legally Each client shall be nity to maintain an ongoing or his family through such the facility and visits outside thall be submitted at least the of a minor resident, or the terson of an adult resident. The iting or take the form of a focus on the client's ting individual goals. S. Each client shall have based on her/his choices,				

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL019-023	B. WING			R-C 0/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
			RTIN LUTHER KING			
GRIFFIN I	HOUSE	SILER C	ITY, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ODOGO DEFEDENCES TO THE ADDRODUATE DATE		
V 291	Continued From page or legal system is inv safety issues become	olved or when health or	V 291			
	facility failed to coord clients received servi devices and guardiar support and address three audited clients Review on 10/8/18 of -Admission date of 8/9-Diagnoses of Unspe Spectrum by History, Impaired Cognitive F Disability, Moderate, Leukoplakia, Allergic Hearing Impairment (ew and interviews, the inate services to ensure ces including medical aship representation to personal care for one of (#1). The findings are: f Client #1's record revealed: (26/15.) cified Schizophrenia Other Psychotic Disorder, unctioning, Intellectual Diabetes, Hypertension, Rhinitis, Hyperlipidemia, and				
	Evaluation dated Nov-"It appears that [clied below average and c #1's] cognitive function communication skills standard score of 21 living skills, socialization obtained due to it terms of communication two-step direction and three-step directions difficult to understand [Client #1] is mostly it skills, including taking	fell in the low range with a Standard scores for daily tion, and motor skills were assufficient information. In ion skills, [client #1] follows				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		MHL019-023	B. WING		R-C 10/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GRIFFIN H	IOUSE	323 MAR	TIN LUTHER KI	NG BOULEVARD	
GRIFFINF	1003E	SILER CIT	ΓY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 291	Continued From page	2	V 291		
V 291	minor cuts, washes coperform maintenance #1] is able to order a food restaurant and cosafely. [Client #1] is after making a purchas what the colors on a sound know the meaning signs, such as enter, indicating that a store—"The results from the [client #1] in the moderange. Testing observinformation provided deficits in adaptive furcommunication, daily functioning. These removed the medically necessary is and the effects of [client #1] from being maintain an adequate least restrictive setting. Review on 10/8/18 of Evaluation dated Sep—"[Client #1's] reading skills are all in the extend to considered furtasks or day-to-day in the safety and the considered furtasks or day-to-day in the safety and the extended the considered furtasks or day-to-day in the safety and the considered furtasks or day-to-day in t	eted, knows how to care for lothing and knows how to tasks as needed. [Client complete meal in the fast arries or stores money not able to count change ase. [Client #1] recognizes street light mean, but does g of certain community exit, poisonous or phrase is closed. " It intellectual testing placed erate mental retardation vations as well as by [client #1] indicate severe inctioning including living skills and social esults support a diagnosis of ardation. [Client #1] should er for services and benefits hiatric and developmental ctual limitations as all are to ameliorate the symptoms ent #1's] disability, to ensure health and safety to prevent exploited by others, and to equality of life within the grossible." Client #1's Psychological of tember 13, 2018 revealed: greenely low range and would inctional for most vocational independent living. As see manager's] responses to	V 291		
	functioning skills are in the extremely low range of adaptive functioning. This indicates [client #1] is performing at a level that is significantly below her				

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Division	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
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MHL019-023		B. WING		10/08/2018	
			•		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		323 MAR	TIN LUTHER KIN	NG BOULEVARD	
GRIFFIN H	IOUSE	SII FR CI	TY, NC 27344		
			11,110 27044		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
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				,	
V 291	Continued From page	3	V 291		
	Continuou i rom page	,			
	same-aged peers in a	all expected daily living			
	activities, including ef	fectively taking care of			
		er time, completing home			
		g the community, utilizing			
	functional academic s	-			
		n and safety, socializing,			
	developing recreation	al activities and hobbies,			
	and coping with stres	sors. These results are			
	consistent with the ex	aminer's impressions of			
	[client #1's] overall ab	ilities and should be			
	-	esentation of [client #1's]			
	-	nt #1's] measured cognitive			
	_				
	<u> </u>	nd several global adaptive			
		1] meets the criteria from			
	_	Manual % for intellectual			
	disability (Intellectual	Developmental Disorder,			
	formerly Mental Retai	rdation), Moderate, 319.			
	[Client #1] appears to	have a longstanding history			
		nts based upon collateral			
	-	with noted decompensation			
		ears that might be related to			
	medication side effect				
	, ,,	ension and diabetes),			
	and/or [client #1's] ps	ychotic disorder. [Client #1]			
	will likely experience	significant difficulties in a			
	wide variety of situation	ons that require			
	age-appropriate- insig				
	reasoning abilities. In				
		en exhibit difficulties with			
	•				
		impulsivity, and reduced			
	behavioral control. [C				
	self-sufficiency is unli	kely to improve in the			
	future."				
	-Recommendations:				
		re 24-hour supports and			
		n the foreseeable future.			
		ue to need close supervision			
in the form of the presence of at least one other					

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responsible adult to provide [client #1] with

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DIVISION	of Health Service Regu	lation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED					
				D 0					
		B. WING		R-C					
		MHL019-023	B. WING		10/08/2018				
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STA	TE ZIP CODE					
NAME OF T	NOVIDEN ON OUT FIEN								
GRIFFIN H	GRIFFIN HOUSE 323 MARTIN LUTHER KING BOULEVARD								
		SILER CI	TY, NC 27344						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)				
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE				
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE				
				DEFICIENCY)					
V 291	Continued From page	Δ. A	V 291						
V 20 1	Continued From page	, -	* 20 :						
	companionship and to	o deal with any significant							
	events that may arise	. Given [client #1's] past							
	_	inctioning, [client #1] would							
		e daily living tasks without							
	assistance, and unab								
	· ·	nances without assistance.							
	Thus, she will be in no								
	_ =	nue to require a high level of							
		benefit from continued							
		ntial or group home facility							
	that can assist [client								
		functioning and support her							
	mental health. In reg								
	communication, [client #1] requires assistance to								
	learn skills such as cl	-							
	_	and needs, consistently							
	_	n they are talking, providing							
	-	s, listening closely for at							
	least 5 minutes when	others are talking with her,							
	not interrupting others	s, and distinguishing truthful							
	from exaggerated/fals	se claims made by others.							
	[Client #1] will require	more assistance than her							
	peers with structuring	her leisure time, developing							
	a hobby, organizing a	ctivities with others or							
	joining organized grou	ups. [Client #1] also needs							
	support with developi	ng social skills, such as							
		ntaining friendships, showing							
	_	making friends, refraining							
		that might embarrass							
	_	r feelings, and recognizing							
		king an unreasonable							
		o functional academic skills,							
	_	ssistance with managing							
	money, making small								
		· ·							
	telephone numbers, r								
		g notes, locating dates on a							
		ting written forms to apply							
	_	n activities that [client #1]							
will need more assistance with include working on				1					

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activities for an extended period of tie, completing

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			71. 501251110.			
				R-C		
MHL019-023		B. WING		10/0	8/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRIFFIN H	IOHEE	323 MAR7	TIN LUTHER KIN	NG BOULEVARD		
GKIFFINF	1003E	SILER CIT	ΓY, NC 27344			
(V4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(YE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		ı
1/ 004	0 " 15	_	V 004			
V 291	Continued From page	∌ 5	V 291			ı
	activities in a timely m	nanner, saving her money,				ı .
	_	ly, and managing stressors.				ı .
						ı
	With community use,					ı
	assistance with navig					ı
	, , ,	oth ways before crossing				ı
		g information and resources.				ı
		additional assistance with				ı
	following general safe	ety rules and taking				ı
	precautions to protect	t her health, such as taking				ı .
		ng cautious around hot or				ı .
		nome living, [client #1] will				ı .
		nce in completing chores,				ı .
	I	rical appliances, and learning				ı .
	, ,					ı !
		on a stove. [Client #1] also				ı
		n self-care task including				ı
		itting [client #1's] fingernails				ı
		when needed, keeping				ı
	[client #1's] hair neat	during the day, avoiding				ı
	unhealthy foods and	drinks and exercising at				ı
	least 2 hours weekly.					ı
		ring, [client #1] may qualify				ı
	1	from receiving CAP/MR/DD				1
		novations Waiver program				1
		s] adaptive, behavioral,				1
	social, and overall fur					ı
		ictioning.				1
	Into mileon and 40/40/40	Swith Oliver #4 many along				ı
		3 with Client #1 revealed:				1
	,	questions several times and				1
	different ways.					1
	-When asked, client re	eported she would like to				ı
	live alone.					ı
	-Minutes later client m	numbled the word sister.				ı
	-When asked if she w	vanted to live with her sister,				ı
	client said yes.					1
		other questions with yes or				1
	no.	saler queenene mai yee ei				ı
	-Client confirm having	a a hearing aid				1
	_					1
	-Client said she received calls from her sister.					1

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Interview on 10/3/18 with the Peer Support

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _				
	MHL019-023	B. WING			R-C /08/2018	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
001550110105	323 MAR	TIN LUTHER KIN	IG BOULEVARD			
GRIFFIN HOUSE	SILER CI	TY, NC 27344				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 291 Continued From page	1 Continued From page 6					
Specialist revealed: -She worked at Local -Client #1 was assess while in a psychiatric -The LME provided a community supportive servicesShe started working several monthsIt took some time to I -When client #1 was I group home before vi -She made contact wi made an appointment -Client #1 was not able -She was not able to during visitClient #1 could not h -The Executive Direct had no ability to live in #1could not read or w -The Executive Direct the magistrate and de -She reported the fact equipment for client # caller(s)She felt client #1 righ because she was una alone, there was no T client #1 to make her Interview on 10/10/18 revealed: -Client #1's ability to of declined since admitte -In the past client #1 to battery in her hearing	Management Entity. Sment a couple of years ago hospital. Ilist of names to pursue for a living and wraparound on client #1's case for locate client #1. Ocated she contacted the siting. Ith the Case Manager and at to visit. Dowed to take her calls. Italk with client #1 alone Hear over the phone. For informed her client #1 andependently because client write. For told her she would go to be the client #1 incompetent. It to communicate with It were being violated able to speak with client #1 Try system and not allowing own decisions. It with the Case Manager It othings on her own had be the communicate to change the aid. It was able to change the aid. It is down ago to the communicate with the Case Manager It of things on her own had be the communicate to change the aid. It is ment a couple of years ago hospital and was able to change the aid. It is the Case Manager It is the Case Manager	V 291				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
		MHL019-023	B. WING		R-C 10/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
00155011		323 MART	IN LUTHER KIN	NG BOULEVARD		
GRIFFIN H	HOUSE	SILER CIT	Y, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
V 291	Continued From page	e 7	V 291			
	medication when client #1 actually did notClient #1 was in contact with her sisterShe did not think TTY system was needed because client #1 had the hearing aidShe was not sure why client #1 did not have a guardian.					
	Interview on 10/10/18 with the Executive Director/QP revealed: -Client #1's was her own guardianClient #1 sister was involved and provided supportClient #1's family was never able to provide the type of care neededShe talked to client #1's sister about being the guardian in the pastShe spoke with client #1's sister due to Local Management Entity representative visited client #1She reported the representative was planning to transition client #1 from the group home to independent living within 2 weeks of her visitThe representative spoke to client #1 alone.					
	representative questing. She was concerned client #1 out of the graph living setting. She did not know who assessment the representate that decision. Client #1 was not callive independently. She informed client is suggested that she as	pable or had the ability to #1's sister the concern and pplied for guardianship. ition for guardianship on duled for 9/24/18.				

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