STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 A limited follow up survey for the Type A1 was completed on October 8, 2018. This was a limited follow up survey, only 10A NCAC 27G. .0209 Medication Requirements (V118) was reviewed for compliance. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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.	V 118	DHSR - Mental Health OCT 23 2018 Lic. & Cert. Section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 118	Continued From page 1 (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep MARs current affecting 1 of 3 clients (#1). The findings are: Review on 10/02/18 of client #1's record revealed: -40 year old male. -Admission date of 11/15/10. -Diagnoses of Bipolar Disorder with Severe Psychotic Features, Intermittent Explosive Disorder, Mild Mental Retardation, Attention Deficit Hyperactivity Disorder, Agitation, Constipation, Asthma, Hypertension, Dysmetabolic Syndrome, Vitamin D Deficiency, Hypercholesterolemia, Vitamin B Deficiency, Allergic Rhinitis, Insomnia, Atrial Flutter, Over Weight and Tobacco Abuse. - Physician's orders dated 03/29/16, 05/08/18, 04/16/18, 08/05/18 for Chlorhexidine 0.12% (used to clean inside of mouth) Swish and spit 15ml by mouth twice daily; Fluticasone 50mcg (treat nasal congestion, sneezing, runny nose, and itchy or watery eyes) Place 1 spray in each nostril twice daily, Advair 100-50 (used to prevent asthma attacks) Use 1 inhalation by mouth twice daily, Famotidine 20mg (used to treat and prevent ulcers in the stomach and intestines). Review on 10/02/18 of client #1's MARs August and September 2018 revealed transcribed entries	V 118	Thankfully, We do not beleive that any medication Administration had been missed, and this seems Like an example of misinforming Staff on how to document appropriately on MARs. That being said, the fear that medication MAY have run out is enough for us to put measures in Place to ensure no-one @ the Grace Home goes without their Prescribed medications. Para professional staff has been Inserviced on how to properly report the need for med Refills, and we have also Added a ~~Med~~ Section in our updated orientation Procedure ~~to emphasize~~ Specific to Reporting medications that are running low. Additionally, to create an	12/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 118	Continued From page 2 on the back of the MAR for the following medications: Chlorhexidine 0.12% -Approximately 15 "need refills" transcribed. Fluticasone 50mcg -Approximately 10 "need refills" transcribed. Advair 100-50 -Approximately 7 "need refills" transcribed. Famotidine 20mg -Approximately 4 "need refills" "not in home" transcribed. During interview on 10/03/18 client #1 revealed: -He always received his medications. -He had not missed any of his medications. During interview on 10/05/18 the House Lead revealed: -She was new and had just become the House Lead. -None of the client's had run out of medications at the facility. -The staff was documenting on the back of the MAR incorrectly. -The staff was supposed to complete a pharmacy refill form and turn into the Certified Medical Assistant (CMA). -The staff were documenting on the back of the MAR to indicate the medication was running low. -The CMA had inservice the staff on the correct way to request refills. During interview on 10/03/18 the CMA revealed: -Client #1 had never run out of his medications. -The former lead staff was telling staff to transcribe on the back of the MAR when the medication was getting low. -The former lead staff and former CMA was having the lead staff transcribe need refills on the back so they would know it was almost time for a	V 118	additional line of Accountability to ensure no meds Run out. Starting no later than 12/5/18, Group Home Leaders will Conduct Bi-Weekly Med Closet Audits at the Grace Home. These Audits will focus on "ABP" Medications (Anything but Pills) The Home Leader will be Required to Verbally Confirm that All Meds are present and not in need of Refill. If they need a Refill, the home leader must Verbally (immediately) remit this info, as well as Submit appropriate documentation to the Med. Coordinators office the following day. We feel as though these additional Measures & lines of Accountability will Ultimately help Solve the issues that we have faced with Reporting when low	12/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 118	Continued From page 3 refill. -The staff were supposed to transcribe on the pharmacy refill form and turn the form into the CMA. -She had corrected the staff and inservice the staff on the correct way to request refills instead of documenting on the back of the MAR. During interview on 10/05/18 the Program Director revealed: -Every staff had been inservice on Medication Administration by the pharmacy. -He was not aware the staff were documenting on the back of the MAR to indicate the client's needed refills. -The new CMA was on a probation period to determine if she was able to fulfill the job duties.	V 118	on Medications. This will be monitored by the Med Coordinator, and backed up by the Qualified Professional	12/5/18
V 366	27G .0603 Incident Response Requirments 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;	V 366	V366] This Problem has already been resolved in the Grace Home. This issue stemmed from a misunderstanding, Staff Were recording the refusals on the MARs, but were not doing a Level 1 Incident Report, due to the fact the Client has a right to Refuse, This misunderstanding by Staff & the CMA has been resolved through; Verbal Acknowlegement	11/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 (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: (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;	V 366	Grace Staff members, Flyers Placed on the Med Closet Door indicating that "Refusals Are Med Errors, Please call pharmacist & fill out Level 1 Incident Report," And our new e-MAR system ensures we can check the MARs daily and ensure any Med Errors or Refusals have a Level 1 Incident Report Completed. This will be monitored by the Medical Coordinator 11/1/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 5 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I incidents. The findings are: Review on 10/02/18 of facility records from August 2018 until present revealed no documentation of client #1 and client #2's medication refusals. Review on 10/02/18 of client 1's August and September 2018 Medication Administration Record's (MAR) revealed: -Approximately 28 medication refusals. Review on 10/02/18 of client #2's August and September 2018 MAR's revealed" -Approximately 37 medication refusals. During interview on 10/03/18 the Certified Medical Assistant revealed: -She did not know a Level 1 incident report had to be completed for medication refusals. -She would begin recording Level 1's for all medication refusals.	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	V 367	V367 As an Administrator, this is an embarassing deficiency, and it will NOT happen again. In order to ensure that we are Reporting incidents at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 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 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	V 367	the Appropriate Level, All QPs have been Provided a Hard and e-copy of the "Incident Response & Reporting Manual" so they will have a reference on How to "grade" the incident. This manual Provides extensive information on appropriate Reporting, and will be used effective today (10/16/18) in our Incident Reporting Practices In addition to using this tool to more Accurately Reflect future incidents, We will go back and enter the Wrongly monikered Level 1 incidents into the IRIS System as Level 2 incidents, to more accurately. In Order to ensure all incidents are labeled and Reported Correctly, all Incident Reports	12/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 8 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 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 reviews and interviews the facility failed to ensure a critical incident report was submitted to the Local Management Entity	V 367	must be Reviewed & Approved by another Amboside QP or Director before the Incident is "Closed." the QP or director that Reviews the Incident Report must Initial @ the bottom of the Report before it is deemed "Complete." This Practice will be Put in Place ASAP, but will be in full effect no later than December 5, 2018	12/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 9 (LME) within 72 hours as required. The findings are. Review on 10/02/18 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II incident reports had been submitted for August-September 2018. Review on 10/02/18 of client #1's record revealed: -40 year old male. -Admission date of 11/15/10. -Diagnoses of Bipolar Disorder with Severe Psychotic Features, Intermittent Explosive Disorder, Mild Mental Retardation, Attention Deficit Hyperactivity Disorder, Agitation, Constipation, Asthma, Hypertension, Dysmetabolic Syndrome, Vitamin D Deficiency, Hypercholesterolemia, Vitamin B Deficiency, Allergic Rhinitis, Insomnia, Atrial Flutter, Over Weight and Tobacco Abuse. Review on 10/02/18 of the facility's Level 1 report's dated 08/028/18 and 09/12/18 revealed: "-...to the door and said that you might as well call the law cause I'm f****** leaving. I then called [House Lead] and [Qualified Professional (QP)] to inform them of the situation before [Client #1] tried to leave. I then went looking for [Client #1] so that [QP] could have a talk with him. [Client #1] was no where on the property, so I then call the Sheriff. I left to find [Client #1], but I could not find him. So my supervisor informed me to go back to the house in case he came back to the home. The Sheriff found [Client #1] brought him back to the home. I called [QP] to let her know that the Sheriff brought [Client #1] back to the home. [QP] had a talk with [Client #1] over the phone. [QP] informed me to give [Client #1] another cigarette and to just send him to bed."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 10 "On 09/12/18 at approximately 5:26pm [Client #1] went into behavior mode. Due to the fact that he was told over the phone by [House Lead] that if he chest is hurting he do not need to smoke anymore cigarettes. [Client #1] became very upset. He stormed into the house yelling f*** you b**** while going into his room to get his shoes. He also yelled out replying you gonna make me walk and leave this house, I'm going to do that. I tried to talk to [Client #1] but he refused to listen and ran down the road. I then called 911 for the Sheriff's Department at 5:28pm. Called House Lead at 5:32pm and also [QP] at 5:35pm. The Sheriff arrived at the house at approximately 5:33pm, I then explained to the Sheriff what happened. The Sheriff replied that he did not see [Client #1] walking down the road. He said that he was going back to see if he see him, I told the Sheriff that I would stay here just in case [Client #1] would try to come back to the house. Within maybe 5 minutes the Sheriff came back to the house with [Client #1]. [Client #1] was upset yelling that he did not want to be here in this home anymore and that he wanted to kill his-self aloud in front of me and the Sheriff. I then asked [Client #1] how was he thinking about hurting himself, [Client #1] did not respond. The Sheriff and myself then talked to [Client #1] to calm him down. I asked [Client #1] was his chest still hurting, [Client #1] replied no and that he wanted another cigarette. The Sheriff told me that I cannot refuse him his cigarettes. I gave [Client #1] his pack of cigarettes, [Client #1] became to be in a really good mood." During interview on 10/05/18 the QP revealed: -Client #1's baseline behavior was leaving the facility. -She did not know she had to do a level II incident	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-270	A. BUILDING: _____ B. WING _____	R 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

(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 11 report every time the police were called. -She thought a Level II only had to be completed if the client was arrested. -She felt like they would be doing Level II's all the time due to his behavior of leaving the facility. -She would begin doing level II's for each time the police were called and had to assist with behaviors at the facility.	V 367		