STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
THE PERIOD CONTROL OF		JIVIDEIX.	A. BUILDING:				
		MHL092-950		B. WING			C 08/2019
NAME OF	PROVIDER OR SUPPLIER	-	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ABLIND	ANT GRACE FAMILY (CARE HOME INC	5040 KAP	LAN DRIVE			
ABUNDA	ANT GRACE FAMILY	CARE HOWE INC	RALEIGH	, NC 27606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	TS		V 000			
	2019. The complair Intake #NC0015330 Deficiencies were of This facility is licens category: 10A NCA	sed for the following C 27G .5600A Supe	53088 and tiated.				
V 118	Living for Adults wit 27G .0209 (C) Med	In Mental lillness. lication Requirement	ts	V 118			
	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included and individual control of the privileged to prepare (4) A Medication Actual drugs administered current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests	ninistration: non-prescription druged to a client on the valuthorized by law to pall be self-administer uthorized in writing be cluding injections, shoy licensed persons, a trained by a register legally qualified per re and administer mediministration Record red to each client muss administered shallely after administration	written prescribe red by py the all be or by pred nurse, reon and redications. (MAR) of ust be kept be on. The drug; ug; red; and ring the ges or				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	COM	(X3) DATE SURVEY COMPLETED		
		MHL092-950	B. WING			C 08/2019
	PROVIDER OR SUPPLIER	CARE HOME INC 5040 KAI	DDRESS, CITY, ST PLAN DRIVE I, NC 27606	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa file followed up by a with a physician.	ge 1 appointment or consultation	V 118			
	facility failed to ass for 1 of 3 audited cl failed to assure me	ion,interview, record review the ure MARs remained current ients (#3). The facility also dications were available to be escribed for 1 of 3 audited	:			
	Review on 8/07/19 -an admission date -Diagnoses include Hypertriglycerdemia knee, Tardive Dysk -A physician's order Clonazepan 1 mg to by mouth at bedtim -MAR for July 2019 evidence of docum	d: Prediabetic, a, Chronic Pain of the left inesia & Seizures r dated 5/23/19 for o be administered once daily e (used to treat seizures) and August 2019 had no entation that the above ministered on 7/01/19 thru				
	administered the m failed to document reported signing the During interview on Professional report been documented a	8/07/19 Staff #1 reported he edications on those dates but he had given them. Staff e count sheet daily. 8/07/19 the Qualified ed medications should have as given on the medication rd and on the count sheet.				

Division of Health Service Regulation

STATE FORM 6899 4A4411 If continuation sheet 2 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					O DATE SURVEY COMPLETED	
		MHL092-950	B. WING		08/0) 8/2019
	PROVIDER OR SUPPLIER	CARE HOME INC 5040 KAF	DRESS, CITY, S LAN DRIVE , NC 27606	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	b. The following evidence reveals the facility's failure to assure medications were available to be administered as prescribed.					
	revealed: - an admission date - an FL2 dated 6/12 Paranoid Schizophi Disability, Hyperten	nd 8/8/19 of client #4's record e of 7/30/19 g/19 with diagnoses including renia, Developmental sion and Type II Diabetes r dated 6/12/19 for Colace 100				
	mg to be given once Ranitidine 150 mg a given once daily - MAR for August 20 reflect the above m	e daily at hour of sleep, and Clonazepam 0.5 mg to be 019 had no documentation to edications were administered idine or Clonazepam was				
	AM of client #4's me	119 at approximately 11:15 edications revealed Colace 150 mg and Clonazepam 0.5 nt.				
	the medications had been delivered by the	on 8/7/19, staff #1 reported d been ordered but had not ne pharmacy yet. Staff #1 ed the medications to be				
		on 8/8/19, the Qualified ed the above medications that day.				
V 133	G.S. 122C-80 Crim	inal History Record Check	V 133			
	G.S. §122C-80 CRI CHECK REQUIRED	MINAL HISTORY RECORD D FOR CERTAIN				

Division of Health Service Regulation

STATE FORM 6899 4A4411 If continuation sheet 3 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		* *	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. BOILDING.		С	
		MHL092-950	B. WING			8/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ABUNDA	ANT GRACE FAMILY	CARE HOME INC	LAN DRIVE , NC 27606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 133	APPLICANTS FOR (a) Definition As a "provider" applies to program and any properties that is lice Chapter. (b) Requirement provider licensed un applicant to fill a possible applicant to have a conditioned on concriminal history recent the applicant has belies than five years is conditioned on concriminal history recent applicant has belies than five years is conditioned on concriminal history recent applicant has befive years or more, on consent to a Stacheck of the applicant criminal history recent applicant has befive years or more, on consent to a Stacheck of the applicant criminal history recent as subsection. Except as subsection, within for the conditional offershall submit a required by the conduct and check required by the G.S. 114-19.10, the return the results of record checks for ecovered by Public L.	EMPLOYMENT. used in this section, the term of an area authority/county rovider of mental health, ability, and substance abuse insable under Article 2 of this An offer of employment by a inder this Chapter to an isition that does not require the in occupational license is issent to a State and national ord check of the applicant. If iteen a resident of this State for it, then the offer of employment onsent to a State and national ord check of the applicant. The istory record check shall ithe applicant's fingerprints. If iteen a resident of this State for then the offer is conditioned ithe criminal history record ant. A provider shall not it who refuses to consent to a ord check required by this otherwise provided in this ive business days of making in of employment, a provider est to the Department of 114-19.10 to conduct a ord check required by this init a request to a private State criminal history record this section. Notwithstanding is Department of Justice shall if national criminal history imployment positions not	V 133			

DIVIDION	Of Fleatin Service IN			ı		1	1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NU	MBER:	A. BUILDING:		COMPLETED	
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		MHL092-950		B. WING		08/08/2019	
		WITILU32-330				00/0	0/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			5040 KAP	LAN DRIVE			
ABUNDA	NT GRACE FAMILY O	CARE HOME INC	RAI FIGH	NC 27606			
	OLIMANA DV. OTA	TEMENT OF DEFICIENCIE			DDOL/IDEDIO DI ANI OF CODDECTI	ON	
(X4) ID PREFIX		TEMENT OF DEFICIENCIE MUST BE PRECEDED BY		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMA		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
V 133	Continued From pa	ige 4		V 133			
	Criminal Records C	Check Unit. Within fiv	6				
		eceipt of the national					
		n, the Department of					
		es, Criminal Records					
		e provider as to whet					
		d may affect the emp					
		no case shall the res					
		story record check be					
		roviders shall make					
		cation that a criminal					
		mpleted on any staff					
		ounty that has adopte					
		dinance and has acc					
		ninal Information data					
		half of a provider a S					
		ord check required b					
		provider having to su					
		artment of Justice. In					
		all commence with the					
		ord check required b	y this				
		ousiness days of the					
		employment by the p					
		nformation received					
		ntial and may not be					
		ant as provided in su	ubsection				
	(c) of this section. F						
		n "private entity" mea					
	business regularly e	engaged in conductir	ng				
	criminal history reco	ord checks utilizing p	ublic				
	records obtained from						
		oplicant's criminal his	tory				
		ls one or more convi					
	a relevant offense.	the provider shall co	nsider all				
		ors in determining w					
	hire the applicant:						
		eriousness of the crir	ne.				
	(2) The date of the						
		person at the time of	the				
	conviction.	Jordon at the time of	uic				
	COTTVICTION.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE S	
		A. BUILDING:			
	MHL092-950	B. WING		08/08	, 8/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ABUNDANT GRACE FAMILY	CARE HOME INC	PLAN DRIVE I, NC 27606			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
commission of the (5) The nexus between the person and the filled. (6) The prison, jail, rehabilitation, and operson since the discovered a relevant offense. The fact of conviction shall not be a bar to listed factors shall lift the provider disqualification of the provider may discovered the criminal history to the disqualification of the criminal history to the disqualification of the criminal history to the disqualification of the criminal history (d) Limited Immunion or employee of a promplies with this scivil liability for: (1) The failure of the individual on the bath of the criminal history (2) Failure to check criminal offenses if history record check compliance with the (e) Relevant offense if history record check compliance with the (e) Relevant offense if history record check compliance with the (e) Relevant offense if history record check compliance with the (e) Relevant offense if history record check compliance with the relevant offense if history record check compliance with the relevant offense in federal criminal history record check compliance with the relevant offense in federal criminal history record check compliance with the relevant offense in federal criminal history record check compliance with the relevant offense in federal criminal history relevant offense in federal criminal history resons needing metallic the relevant offense in federal criminal history resons needing metallic the relevant offense in federal criminal history resons needing metallic the relevant offense in federal criminal history resons needing metallic the relevant offense in federal criminal history resons needing metallic the relevant offense in federal criminal history record check cri	aces surrounding the crime, if known. Ween the criminal conduct of a job duties of the position to be probation, parole, employment records of the ate the crime was committed. It commission by the person of ion of a relevant offense alone of employment; however, the be considered by the provider. In utilities an applicant after the relevant factors, then the cose information contained in the record check that is relevant on, but may not provide a copy orly record check to the section shall be immune from the provider to employ an asis of information provided in the record check of the individual. It is requested and received in the comployee's criminal of the employee's criminal of the individual of the individual of the employee's criminal of the individual of the individual of the employee's criminal of the individual of the i				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		С	
	MHL092-950	B. WING		_	8/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ABUNDANT GRACE FAMILY	CARE HOME INC	LAN DRIVE , NC 27606			
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX (EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	COMPLETE DATE
V 133 Continued From pa	ige 6	V 133			
crimes include the any of the following General Statutes: A Issuing Monetary S Endangering Execu Article 6, Homicide: Sex Offenses; Artick Kidnapping and Ablinjury or Damage b Incendiary Device of and Other Housebr Other Burnings; Art Robbery; Article 18 False Pretenses an Obtaining Property Fraudulent Use of Article 19B, Financ Act; Article 20, Frau 26, Offenses Again Decency; Article 27, Prostitut 29, Bribery; Article Office; Article 35, C Peace; Article 36A, Article 39, Protection of the Falntoxication; and Ar Crime. These crimes ale of drugs in viol Controlled Substan 90 of the General Soffenses such as siviolation of G.S. 18 impaired in violation G.S. 20-138.5. (f) Penalty for Furniapplicant for emplosupplies, or otherw	criminal offenses set forth in Articles of Chapter 14 of the Article 5, Counterfeiting and Jubstitutes; Article 5A, Jutive and Legislative Officers; Article 7A, Rape and Other 18 et 8, Assaults; Article 10, duction; Article 13, Malicious y Use of Explosive or 19 or Material; Article 14, Burglary 19 eakings; Article 15, Arson and 19 eakings; Article 15, Arson and 19 eakings; Article 21, Forgery; Article 17 eating 19 eakings; Article 21, Forgery; Article 19 eating 19 eakings; Article 21, Forgery; Article 19 eating 19 eakings; Article 21, Forgery; Article 19 eating 19 eatings; Article 28, Perjury; Article 19 eatings; Article 28, Perjury; Article 19 eatings; Article 28, Perjury; Article 19 eatings; Article 29 eatings; Article 30, Computer-Related 19 eatings; Article 50, Computer-Related 19 eatings 1	V 133			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		MHL092-950	B. WING			C 08/2019
	PROVIDER OR SUPPLIER	SARE HOME INC. 5040 KA	DDRESS, CITY, S PLAN DRIVE I, NC 27606	TATE, ZIP CODE		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 133	criminal history receshall be guilty of a (g) Conditional Empemploy an applicant obtaining the result check regarding the following requirement (1) The provider shippior to obtaining the criminal history recesubsection (b) of the fingerprint cards as (2) The provider shippion can be criminal history recesubsection (b) of the fingerprint cards as (conditional employing 2001-155, s. 1; 200	ord check under this section Class A1 misdemeanor. Doloyment A provider may at conditionally prior to s of a criminal history record e applicant if both of the	V 133			
	failed to assure a s	view and interview, the facility tatewide criminal history equested within 5 business				
	- a hire date of 6/28 - a county criminal	f staff #1's record revealed: 8/19 check completed 12/13/18 on 8/7/19, staff #1 reported				
	he had worked at the During an interview	ne facility one month. on 8/8/19, the Qualified ed she was aware no				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED		
		MHL092-950		B. WING			C 08/2019
NAME OF I	PROVIDER OR SUPPLIER	STI	REET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ABUNDA	ANT GRACE FAMILY O	CARE HOME INC		NC 27606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 8		V 133			
		d been completed. The or inform the Administrator					
V 290	27G .5602 Supervis	sed Living - Staff		V 290			
	numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of compresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not I the client continues the home or common specified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders should or staff present clients present. However, the governing slee emergency back-up the governing body (2) children of developmental disation one staff present for present and two staff present and two staff present during present during body (2) children of developmental disations one staff present for present and two staff present during present during present during body (2) children of developmental disations one staff present for present during present during present during present during present during body (2) children of developmental disations one staff present for present during p	is above the minimum in Paragraphs (b), (c) and determined by the facility ond to individualized clies one staff member shall be when any adult client is hen the client's treatment that the client is gin the home or community without supervision to be capable of remain unity without supervision time. The plan shall be reviewes than annually to ensity to be capable of remain unity without supervision time. The plan shall be reviewed to be capable of remain unity without supervision time. The plan shall be reviewed that is present: In a facility in the fratios when more than client is present: In a facility in the fration when more than client is present: In a facility in the fration when more than client is present: In a facility in the fration when more than client is present: In a facility in the fration when more than client is present with a minimal procedure of the procedures determined to the client in the procedure of the community of the client in the client is present for every four in the client in the client is present for every four in the client is present for every for in the client is present in the client	e on the one on the one one one one one one one one one on				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL092-950	B. WING		08/0	8/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ABUNDA	ANT GRACE FAMILY (A DE HOME INC	LAN DRIVE , NC 27606			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE
V 290	Continued From pa	ge 9	V 290			
	diagnosis is substa (1) at least of duty shall be trained withdrawal symptor secondary complication; and (2) the service	es of a certified substance nall be available on an				
	This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 2 of 3 audited clients (#3, #4) were supervised by staff in the home. The findings are:					
	Observation on 8/7/19 at 10:30 AM revealed there was no answer at the door. At approximately 10:35 AM staff #1 arrived at the facility with juice and grocery items. Once in the house, 5 of 5 clients were found to have been in the home unsupervised.					
	revealed: - admission dat - diagnoses of Hypertriglycerdemia knee, Tardive Dysk - a treatment pl not recommended unsupervised time admission sui 5/23/19 "The Adn client has agreed th	Prediabetic, a, Chronic Pain of the left inesia, Seizures an dated 6/20/19 with " it is that he be approved for				

Division of Health Service Regulation

STATE FORM 6899 4A4411 If continuation sheet 10 of 15

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MUU aaa asa	B. WING		C		
		MHL092-950			08/0	8/2019	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
ABUNDA	NT GRACE FAMILY	CARE HOME INC	LAN DRIVE , NC 27606				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 290	Continued From pa	ge 10	V 290				
	During interview on 8/8/19 the Qualified Professional reported client #3 was allowed unsupervised time but she had not updated the plan.						
	 b. Review on 8/7/19 of client #4's record revealed: - an admission date of 7/30/19 - an FL2 dated 6/12/19 with diagnoses including Paranoid Schizophrenia, Developmental Disability, Hypertension and Type II Diabetes - an admission assessment dated 7/30/19 that included client #4 must register as a sex offender - a Level of Supervision assessment completed by the Qualified Professional and dated 7/30/19 revealed client #4 was not eligible for unsupervised time 						
	During interview on 8/7/19 staff #1 reported all clients in the home had unsupervised time. Staff #1 reported he had just gone to the store for a "few minutes".						
	Professional report	on 8/8/19, the Qualified ed she would review client including level of supervision e staff.					
V 291	27G .5603 Supervis	sed Living - Operations	V 291				
	six clients when the developmental disa on June 15, 2001, a than six clients at the	OPERATIONS cility shall serve no more than e clients have mental illness or abilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-950	B. WING		C 08/08/2019	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	012010
ABUNDA	ANT GRACE FAMILY (CARE HOME INC	LAN DRIVE , NC 27606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 291	maintained betwee qualified profession treatment/habilitation (c) Participation of Responsible Persoprovided the opport relationship with he means as visits to the facility. Reports annually to the pare legally responsible Reports may be in conference and shaprogress toward modificativity opportunities needs and the treat Activities shall be dinclusion. Choices or legal system is in	nation. Coordination shall be in the facility operator and the hals who are responsible for on or case management. The Family or Legally in. Each client shall be tunity to maintain an ongoing or or his family through such the facility and visits outside is shall be submitted at least ent of a minor resident, or the person of an adult resident. Writing or take the form of a hall focus on the client's eeting individual goals. The shall have is based on her/his choices, the tent/habilitation plan. The esigned to foster community may be limited when the court involved or when health or the a primary concern.	V 291			
	Based on observation interviews, the facil	et as evidenced by: ion, record review and ity failed to assure services o meet the needs of 1 of 3 . the Findings are:				
	there was no answ approximately 10:3 facility with juice an	5 AM staff #1 arrived at the d grocery items. Once in the swere found to be in the				
	Review on 8/7/19 of an admission date	of client #4's record revealed: e of 7/30/19				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL092-950	B. WING		08/0) 8/2019	
NAME OF PROVIDER OR SUPPLIER ABUNDANT GRACE FAMILY CARE HOME INC STREET ADDRESS, CITY, STATE, ZIP CODE FOUNDATION OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RALEIGH, NC 27606							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 291	- an FL2 dated 6/12 Paranoid Schizophi Disability, Hyperten - an admission assi included client #4 m - a Level of Supervi by the Qualified Pro revealed client #4 w unsupervised time - no evidence in the had been updated i Review on 8/8/19 o Registry revealed n was registered as a During an interview guardian reported ti going to register clie registry. The guardi days to update his a registry. The Qualified Profe was supposed to be with the sex offende yet. The QP reporte address had to be u moving. The QP re or the Owner would During an interview Sheriff's officer repo	2/19 with diagnoses including renia, Developmental sion and Type II Diabetes essment dated 7/30/19 that nust register as a sex offender ision assessment completed of of of of other fields of other including the sex of other fields of other including the sex of other fields of other including the sex of other includin	V 291				
V 513	27E .0101 Client Ri Alternative	ights - Least Restictive	V 513				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
					C			
		MHL092-950	B. WING		08/0	8/2019		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
ABUNDA	ABUNDANT GRACE FAMILY CARE HOME INC 5040 KAPLAN DRIVE RALEIGH, NC 27606							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE		
V 513	Continued From pa	ge 13	V 513					
	that promote a safe These include: (1) using the appropriate settings (2) promoting skills that are altern self or others; (3) providing meaningful to the c (4) sharing of the client/legally res (b) The use of a reprocedure designed always be accompainsure dignity and mintervention. These (1) using the and	all provide services/supports and respectful environment. least restrictive and most and methods; gooping and engagement actives to injurious behavior to choices of activities lients served/supported; and foontrol over decisions with sponsible person and staff. strictive intervention do to reduce a behavior shall anied by actions designed to espect during and after the						
	governing body failed promoted a respect least restrictive sett clients (#1, #2, #3, #3). Observation on 8/8 of the kitchen reveal.	et as evidenced by: on and interview, the ed to assure the home tful environment and used the ing and methods for 5 of 5 #4, #5). The findings are: /18 at approximately 10:40 AM aled a lock on the refrigerator present but not in the locked						
	During an interview	on 8/8/19, staff #1 reported						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. B.	OILDING.				
		MHL092-950	B. W	ING			8/2019	
NAME OF F	PROVIDER OR SUPPLIER				TATE, ZIP CODE			
ABUNDANT GRACE FAMILY CARE HOME INC 5040 KAPLAN DRIVE RALEIGH, NC 27606								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 513	Continued From page 14			513				
	to bed and was unleaded. Staff #1 report	s locked when the clients vocked in the morning at 5: ed the lock was in place might get up" and eat fooght.	00					
V 736	27G .0303(c) Facility and Grounds Maintenance		nce V 7	'36				
	EXTERIOR REQUI (c) Each facility and maintained in a saf	803 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and ord e kept free from offensive						
	Based on observati failed to assure the	et as evidenced by: ion and interviews, facility home was maintained in manner. The findings are:	а					
	10:35am revealed: -smoke detectors b	7/19 at approximately eeping in the living room a client #2's bedroom.	area,					
	he changed all the detectors but there	on 8/07/19, staff #1 report batteries in the smoke may be another problem se batteries and the beepin	since					
		on 8/07/19, client #2 repos s been beeping for a while						