STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-415	A. BUILDING: _____ B. WING _____	R 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL'S PLACE	2815 CASCADILLA STREET DURHAM, NC 27703

(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 An annual, follow-up and complaint survey was completed on September 16, 2021. The complaint (intake #NC00179840) was substantiated. Deficiency cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community	V 291		

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V 291	Continued From page 1 inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure clients be provided the opportunity to maintain an ongoing relationship with his or her family through such means as telephone calls and visits to the facility and visits outside the facility affecting one of three audited clients (FC#3). Review on 9/15/21 of FC#3's record revealed: -Admission date of 3/1/21. -Diagnoses of Moderate IDD, Intermittent Explosive Disorder, Down Syndrome and Cerebral Palsy. -Parent had guardianship. -Discharged 9/10/21. Interview on 9/16/21 with FC#3's Guardian revealed: -Guardian contacted surveyor during visit with her worker. -She was FC#3's biological mother and guardian. -She reported limited amount of contact with FC#3 since admitted. -She was not able to speak to FC#3 on the phone when she called the group home. -Most of the time there was no response. -She would leave a message and never received a call back. -She denied calling the home all hours of the day and night. -She denied verbally abusing and making verbal threats to harm the Owner. -She reported there was no in person visits with	V 291		

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V 291	Continued From page 2 FC#3. -When she spoke to the Owner there was always an excuse why FC#3 was not available. -She felt the Owner was trying to take FC#3 away from her. -She was not even sure if FC#3 lived at the group home because she was unable to see her. -She wanted FC#3 out of the group home. -Confirmed FC#3 was discharged on 9/10/21. -She felt comfortable with FC#3's new placement. Interview on 9/15/21 with FC#'s Care Coordinator revealed: -She was FC#3's care coordinator since 2019. -FC#3 was admitted to the group home March 2021. -The guardian had difficulties contacting the Owner and visiting. -The Owner of the group home would not let FC#3's guardian visit. -The Owner never answered her phone or returned messages even when she called. -The guardian did not know where FC#3 stayed because she was unable to see her. -The Owner and guardian initially had a rapport. -The Owner called all" the shots" before FC#3 was admitted. -The Owner told her in November 2020, the FC#3's guardian wanted the client to move into her group home. -The guardian did not tell her that for months. -The Owner had known the family for over 20 years. -The Owner had been working and helping them for years. -She did not know what happened, but the guardian wanted FC#3's out the group home. -She knew the guardian wanted FC#3 in a group home because lack of contact. -FC#3 was always living with the grandmother	V 291		

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V 291	Continued From page 3	V 291		

and guardian.
-The grandmother and guardian did not want FC#3 to go to a group home for no longer than a month.
-There was a different understanding regarding the underlining reason for placement.
-When the FC#3's guardian learned her benefits would go to the group home they did not want to admit client.
-FC#3's guardian and her worker called the Provider the day of attempted visit on 7/28/21.
-FC#3's guardian and her worker showed up at the home.
-The guardian told her the van was in the parking space and seen someone walking in the house.
-FC#3's guardian told her there was no answer and left message.
-She was on the phone while FC#3's guardian went to the house.
-She encouraged FC#3's guardian to call the police to conduct a wellness check.
-FC#3's guardian and her worker left before the police arrived.
-The guardian had not been able to see FC#3 since admitted.
-The Owner never mentioned the threats to her.
-She spoke with the Owner regarding the attempted visit.
-Owner never informed her of any verbal threats made by FC#3's guardian until the attempted visit.
-After an attempted visit the guardian's worker scheduled a visit for 8/13/21.
-The guardian met with the FC#3 on 8/13/21 in the park.
-Prior to the visit the guardian had concerns because she was unable to visit and talk to FC#3.
-The guardian wanted FC#3 out the group home.
-FC#3 was discharged on 9/10/21.
-The guardian and her worker picked up FC#3

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V 291	Continued From page 4 and her medication. Interview on 9/15/21 and 9/16/21 with the Owner/Clinical Director revealed; -She called the police during FC#3's visit with guardian on 8/13/21 and when discharge 9/10/21. -She wanted the police to supervise the visit due to reported verbal threats made towards her by the guardian. -FC#3's guardian came to the group home unannounced on 7/28/21. -She did not feel safe to open the door. -She opened when the police arrived. -The guardian contacted the police during the attempted visit. -The guardian and her worker left prior to the police arriving -She reported discharging FC#3 due to the guardian violated the no violence policy. -She then reported receiving a written notice of discharge via email. -There was no problems with FC#3 in the home. -FC#3's guardian was the one with the problem. -She reported FC#3 was threatening staff and stated that she would bring down the group home. -This started in April 2021; client was admitted in March 2021. -The guardian apparently was upset; claiming that the facility was taking FC#3 to different states and hiding her. -She reported FC#3's guardian was making accusations about the group home and treatment of the client. -She denied mistreatment of FC#3. -She reported contacted FC#3's care navigator who supervised the care coordinator. -She reported to the care navigator about FC#3's guardian's behavior and how she was involuntary committed 3-4x's this year.	V 291		

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V 291	Continued From page 5 -FC#3's guardian would call from the hospital all hours of the day and night. -She reported FC#3's was Moderate MR and the guardian's behavior caused client distress. -FC#3's guardian would ask client where she was and what state. -She reported after FC#3's guardian phone calls, the client would be very disturbed. -The care coordinator emailed her asking for client to be discharged. -This is after she told them what was going on. -The guardian was homeless. -She reported FC#3's guardian was threatening her on the phone all hours of the day. -She reported FC#3's guardian was able to talk to the client every time she called. -FC#3's guardian was as belligerent to the client as she was to her. -FC#3's guardian came to the group home unannounced with an unidentified person. -She reported due to the continuous threats made by FC#3's guardian she did not open the door. -FC#3's guardian called the police. -The police arrived and then she opened the door and spoke to the police. -FC#'s guardian and her worker left before the police arrived. -She explained to the police of FC3's guardian arrived unannounced, how she made threats verbally and physically attacked people all for accusing them for killing her children. -She reported she thought FC#3's guardian was there to make good on her threats. -Confirmed there was no documentation regarding the threats made. -Confirmed the verbal threats was not reported to the police. -Confirmed she informed the police of the past verbal threats during the attempted visit. -Confirmed she did not contact the police for	V 291		

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V 291	Continued From page 6 threats made because "she knew the guardian was crazy." -She reported there was communication via email with the care navigator and care coordinator regarding the threats. -Owner was not able to produce emails per surveyor's request and during exit.	V 291		