Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	SI GORREOTION	IDENTIFICATION NOMBER.	A. BUILDING: _		
		MHL0601444	B. WING		R 11/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
STEPHEN	GREAVES		BERRY LANE		
		CHARLOT	TE, NC 28212		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual and follow- on 11/22/2021. Defic	-up survey was completed iencies were cited.			
		d for the follow service 27G .5600F Supervised Family Living.			
	The survey sample co	onsisted of audit of 1 current			
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons tripharmacist or other leprivileged to prepare (4) A Medication Administered current. Medications arecorded immediately MAR is to include the (A) client's name; (B) name, strength, are (C) instructions for acc (D) date and time the (E) name or initials of drug.	istration: n-prescription drugs shall to a client on the written chorized by law to prescribe be self-administered by chorized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following:			

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		MHL0601444	B. WING		1.	R 1/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
STEPHEN	I GREAVES		YBERRY LANE OTTE, NC 28212			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 118	checks shall be recor	e 1 ded and kept with the MAR pointment or consultation	V 118			
	interviews, the facility drugs were administe order from the persor	ews, observations, and failed to ensure prescription ared based on the written				
	#1's record revealed: -Admitted 06/04/2021 -Diagnosed with Autis Severe Intellectual Di -13 years oldMedication order sig was presented and re -Guanfacine HCL ((Extended Release) 1 (forAttention Deficit H Disorder/ADHD)-	sm Spectrum Disorder and sability. ned and dated 10/13/2021 eviewed on 11/17/2021 for; Hydrochloride Acid) ER I milligram (mg)-lyperactivy 1 tab 2 times per day. ue order for Guanfacine HCL				
	August, September, a -Staff documented and HCL ER 1 mg- 2 time from 08/01/2021-10/3					
	Review on 11/23/202	1 of Client #1's MARs for	1			

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STATE FORM 6899 F39J11 If continuation sheet 2 of 12

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
			D WING		R	
		MHL0601444	B. WING		11/22/2021	
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDER OR SOLT LIER			TE, ZII GODE		
STEPHEN	GREAVES		BERRY LANE			
		CHARLO	TTE, NC 28212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE	
				DEI IGIENCI)		
V 118	Continued From page	2	V 118			
	Continuou i ioni page	, _				
	November 2021 reve	aled:				
	-Administration instru	ctions for Guanfacine HCL				
	ER 1 mg; Give Amou	nt/Quanity: 1 tablet,				
	•	Begin date and Time:				
	10/13/2021.	3				
	-Staff documented ad	Iministration of Guanfacine				
		s per day, 7 am and 9 pm				
	from 11/01/2021-11/1	· · · · · · · · · · · · · · · · · · ·				
		Iministration of Guanfacine				
	HCL ER 1 mg- 1 time					
	•					
	11/11/2021 to 11/17/2	3021.				
	01	10004 - £ Oli - :- £ #41-				
	Observation on 11/18					
	Medications revealed					
	-No Guanfacine HCL	ER 1 mg pill bottle.				
		21 with Staff #1 revealed:				
		anfacine HCL ER 1 mg pill				
	bottle.					
	-Turned the medication	on into the pharmacy.				
	-"The doctor disconting					
	(Guanfacine HCL ER	1 mg) last week".				
	-Did not have a copy	of the discontinue order for				
	Guanfacine HCL ER	1 mg at the facility.				
	Interviews on 11/17/2	019, 11/19/2021 and				
	11/24/2021 the Execu	ıtive Director (ED)/Qualified				
	Professional (QP) rev	vealed:				
	` ,	RN) manages MARs monthly				
		s are updated and provided				
	by Alternative Family	·				
	-"I do not monitor MA					
	-RN charged with upo					
		uanfacine HCL ER 1 mg				
	discontinuation.	admasmo HOL LIV I IIIg				
		tten discontinue order for				
		1 mg-1 tab 2 times a day.				
		imary AFL's understanding				
	of medication adminis	stration guidelines moving				

Division of Health Service Regulation

forward.

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		R
		MHL0601444	B. Wille		11/22/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	
STEPHEN	GREAVES		YBERRY LANE OTTE, NC 28212		
()(1)	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	TION
(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 APPRODEFICIENCY)	ILD BE COMPLETE
V 118	Continued From page	÷ 3	V 118		
	and 11/24/2021 with tunsuccessful due to r	on 11/17/2021, 11/19/2021, the Registered Nurse were no response to phone calls (mailed correspondence prior			
V 131	G.S. 131E-256 (D2) Horification	HCPR - Prior Employment	V 131		
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh	LTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.			
	facility failed to ensur Registry (HCPR) was of 3 Staff (Staff #1, #2	as evidenced by: iew and interviews, the e the Health Care Personnel accessed prior to hire for 3 2 and the Executive Director sional (QP)). The findings			
	record revealed: -Hire date of 08/30/20	Iternative Family Living			

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Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R	
		MHL0601444	B. WING		11/22	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4054 MA	YBERRY LANE			
STEPHEN	GREAVES	CHARLO	TTE, NC 28212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DAIL
			1/404			
V 131	Continued From page	e 4	V 131			
	Review on 11/17/202	1 of Staff #2's personnel				
	record revealed:					
	-Hire date of 08/30/20					
	-Job title of Backup A					
	-HCPR accessed on	06/19/2019.				
	Review on 11/17/202	1 of the ED/QP personnel				
	record revealed:	Tof the LD/QL personner				
	-Hire date of 03/19/20	019.				
	-Job title of ED/QP.					
	-HCPR accessed on	04/20/2020.				
		21 with Staff #1 revealed:				
	-Not sure of his hire d					
	2020.) was around September				
		ry AFL staff for Client #1.				
	Interview on 11/18/20	21 with Staff #2 revealed:				
		date. Started the same time				
	as Staff #1.					
	Served as the Backu	p AFL staff for Client #1.				
	Interview on 11/17/20	21 with the ED/QP revealed:				
	-Hired March 2019.	21 With the EB/Qt Tevedied.				
	-Served as the facility	's ED/QP.				
		perations manager and				
	oversee QPs.	-				
	11/00/00	04 20 0 4 1 2 2 2 2				
		21 with the Administrative				
	Director revealed: -Started with the ager	nov on 10/17/2010				
		essing HCPR prior to the				
	hire of a new employe					
		rith agency at the time of				
		nd the Executive Director				
	(ED)/Qualified Profes					

Division of Health Service Regulation

-No Human Resource department in place during the time of hire for Staff #1, #2 and the ED/QP. -Licensee/owner was responsible for completing

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	.
		MHL0601444	B. WING		1	2/2021
NAME OF D		OTDEET AL		TE 7/D 00DE		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ITE, ZIP CODE		
STEPHEN	GREAVES		BERRY LANE TTE, NC 28212			
			11E, NC 20212	I		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 131	Continued From page	e 5	V 131			
	to her (the Administra	all potential new hires prior				
		developed and implemented				
		ion process to ensure the				
		check prior to the hire of a				
	potential employee.	orieck prior to the time of a				
	poterniai empleyeei					
V 133	G.S. 122C-80 Crimina	al History Record Check	V 133			
	0.0.04000.00.00	WALL HOTODY DECORD				
	-	IINAL HISTORY RECORD				
	CHECK REQUIRED APPLICANTS FOR E					
		ed in this section, the term				
	` '	an area authority/county				
		vider of mental health,				
		lity, and substance abuse				
	T	able under Article 2 of this				
	Chapter.					
		offer of employment by a				
	provider licensed und					
	applicant to fill a posit	tion that does not require the				
	applicant to have an	occupational license is				
		nt to a State and national				
	criminal history record	d check of the applicant. If				
	• • •	n a resident of this State for				
		hen the offer of employment				
		sent to a State and national				
		d check of the applicant. The				
	national criminal histo					
		e applicant's fingerprints. If				
	the applicant has bee	n a resident of this State for				

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five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider

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Division of Health Service Regulation

Bivioleti di Floditii dei vice i tega	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	MHL0601444	B. WING	R 11/22/2021		
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE				

STEPHEN	GREAVES	4054 MAYBERRY LANE CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 6	V 133		
	shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shareturn the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employabi of the applicant. In no case shall the results of national criminal history record check be share with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider is confidential and may not be disclose except to the applicant as provided in subsection of this section, the term "private entity" means a business regularly engaged in conducting	d g g all h k e illity i the ed ble y ed o		
Division of Har	alth Service Regulation			

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
				R		
		MHL0601444	B. WING		11	/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
STEPHEN	I GREAVES		YBERRY LANE			
		CHARLO	OTTE, NC 28212			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 133			V 133			
	records obtained from (c) Action If an apprecord check reveals a relevant offense, the of the following factor hire the applicant: (1) The level and seri (2) The date of the cr (3) The age of the perconviction. (4) The circumstance commission of the cri (5) The nexus between the person and the jour filled. (6) The prison, jail, processed in the date (7) The subsequent carelevant offense.	licant's criminal history one or more convictions of e provider shall consider all es in determining whether to ousness of the crime. ime. rson at the time of the s surrounding the me, if known. en the criminal conduct of b duties of the position to be				
	shall not be a bar to elisted factors shall be If the provider disqual consideration of the reprovider may disclose the criminal history to the disqualification of the criminal history applicant. (d) Limited Immunity. or employee of a procomplies with this secivil liability for: (1) The failure of the individual on the basis the criminal history residual.	employment; however, the considered by the provider. lifies an applicant after elevant factors, then the e information contained in ecord check that is relevant, but may not provide a copy				

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PRINTED: 12/08/2021

Division of Health Service Regulation						APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
		MHL0601444	MHL0601444 B. WING			2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		4054 MA	BERRY LANE			
I STEPHEN GREAVES			TTE, NC 28212			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 133	Continued From page	8	V 133			
	criminal offenses if the history record check is compliance with this second plants. (e) Relevant Offense. "relevant offense" medicated record federal criminal histor indictment of a crime, felony, that bears upon have responsibility for persons needing mer disabilities, or substancimes include the crimany of the following A General Statutes: Artilesuing Monetary Subendangering Executin Article 6, Homicide; A Sex Offenses; Article Kidnapping and Abdulnjury or Damage by Incendiary Device or and Other Housebrea Other Burnings; Article Robbery; Article 18, Efalse Pretenses and Obtaining Property or Fraudulent Use of Cranticle 19B, Financial Act; Article 20, Frauda 26, Offenses Against Decency; Article 26A, Article 27, Prostitution 29, Bribery; Article 31	e employee's criminal section. - As used in this section, ans a county, state, or y of conviction or pending whether a misdemeanor or on an individual's fitness to rethe safety and well-being of stal health, developmental nece abuse services. These minal offenses set forth in ricles of Chapter 14 of the scle 5, Counterfeiting and sostitutes; Article 5A, we and Legislative Officers; riticle 7A, Rape and Other 8, Assaults; Article 10, ction; Article 13, Malicious Use of Explosive or Material; Article 14, Burglary skings; Article 15, Arson and e 16, Larceny; Article 17, Embezzlement; Article 19, Cheats; Article 19A, Services by False or edit Device or Other Means; Transaction Card Crime s; Article 21, Forgery; Article				

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Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL0601444	B. WING		11	R I/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
STEPHEN	I GREAVES	4054 MA	YBERRY LANE			
		CHARLO	OTTE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 133	sale of drugs in viola Controlled Substance 90 of the General Sta offenses such as sal- violation of G.S. 18B impaired in violation G.S. 20-138.5. (f) Penalty for Furnis applicant for employs supplies, or otherwis an employment appli criminal history recor shall be guilty of a Cl (g) Conditional Emple employ an applicant obtaining the results check regarding the following requiremen (1) The provider shal prior to obtaining the criminal history recor subsection (b) of this fingerprint cards as r (2) The provider shal criminal history recor business days after t conditional employm 2001-155, s. 1; 2004	tion of the North Carolina es Act, Article 5 of Chapter atutes, and alcohol-related e to underage persons in -302 or driving while of G.S. 20-138.1 through hing False Information Any ment who willfully furnishes, e gives false information on ication that is the basis for a rd check under this section lass A1 misdemeanor. oyment A provider may conditionally prior to of a criminal history record applicant if both of the tts are met: Il not employ an applicant applicant's consent for rd check as required in a section or the completed equired in G.S. 114-19.10. Il submit the request for a rd check not later than five the individual begins	V 133			
	facility failed to reque criminal records chec	as evidenced by: iew and interviews, the est the required statewide ck no later than five business ual begins conditional				

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		MHL0601444	B. WING		11/22/2021	
					/ = = : = = = :	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
STEPHEN	GREAVES		BERRY LANE			
		CHARLO	TTE, NC 28212		_	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ - /	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		
IAG		,	170	DEFICIENCY)		
1/400	0 " 15	10	V/ 400			
V 133	Continued From page	e 10	V 133			
	employment for 2 of 3	3 Staff (Staff #2 and the				
	Executive Director (E	D)/Qualified Professional				
	(QP). The findings are	e:				
		1 of Staff #2's personnel				
	record revealed: -Hire date of 08/30/20	24.0				
	(AFL) staff	Iternative Family Living				
	` ,	e criminal records check				
	ordered on 06/20/201					
	0.40.04 0 00,20,20					
	Review on 11/17/202	1 of the ED/QP personnel				
	record revealed:	·				
	-Hire date of 03/19/20	019.				
	-Job title of ED/QP.					
	•	e criminal records check				
	ordered on 07/18/201	9.				
	Intoniow on 11/19/20	21 with Staff #2 revealed:				
		date. Started the same time				
	as Staff #1.	date. Started the same time				
	-Served as the backu	p AFL staff.				
		•				
	Interview on 11/17/20	21 with the ED/QP revealed:				
	-Hired March 2019.					
		perations manager and				
	oversee QPs .					
	Intoniow on 11/22/20	121 with the Administrative				
	Director revealed:	21 with the Administrative				
	-Started with the agei	ncv on 10/17/2019				
	•	esting statewide criminal				
	records check prior to					
	employee.					
		ith agency at the time of				
	hire for Staff #2 and t					
		e department in place during				
	the time of hire for Sta	aff #2 and the facility's				

ED/QP. Division of Health Service Regulation

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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	
					F	₹	
		MHL0601444	B. WING		I	2/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
STEPHEN GREAVES CHARLOTTE NC 28242							
CHARLOTTE, NC 28212 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)							
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 133	-Licensee/owner was the statewide crimina potential new hires pr Director's) hire. -Since her hire have of an electronic verificat	responsible for completing I records check for all ior to her (the Administrative developed and implemented ion process to ensure the de criminal record checks	V 133				

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