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By DHSR Mental Health Licensure & Certification at 4:12 pm, May 17, 2022

SAVIN GRACE, LLC
562 OLD DAM ROAD
SELMA, NC 27576
(919) 351-0465

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

RE: SAVIN GRACE, II- 562 OKD DAM ROAD, SELMA, NC 27576
MHL# 051-173
INTAKE # NC00186558

On 4/14/2022 a complaint and annual survey was conducted at that time the complaint was unsubstantiated, however deficiencies were found. All tags were cited were standard level deficiencies.
Savin Grace, CEO [redacted] have implemented a Plan of Correction to all deficiencies noted as follows:

V118 27G .0209 (C) MEDICATION REQUIREMENTS

Savin Grace staff WAS RE-TRAINED ON MEDICATION ADMINISTRATION, each staff passed with 100% and fully understand their responsibility when given medication and reporting medication errors as well as ensuring that a doctors order accompany any medication given to any child placed in Savin Grace care, The Qualified Professional will ensure that all medications given will have a doctors order in the medication administration record. The Qualified Professional and the CEO, will be responsible for reviewing the medications and doctors' orders for every client entering into the facility upon admission. The Qualified Professional will be in charge of ensuring that each medication ordered by a doctor accompany a doctor's order that will be filed in the client medication administration record. The CEO will review all medications weekly for new doctors' orders and to ensure that the doctors order is placed in the medication administration record.

V121 27G .0209 (F) MEDICATION REQUIREMENTS

Savin Grace, CEO [redacted] implemented a medication review form on April hat has become a part in the intake process, the medication review form will be completed upon admission and within six- months of client stay at Savin Grace facility. The Associate Professional will be charged with the task to ensure that the medication review form is completed and necessary appointments are made within six- months with the child's psychiatrist to review all psychotropic medications. This form will be filed in the client record along with the doctor's review of the medications. The medication review forms will be reviewed every 3- months to ensure that each child has a medication review within six months of placement.

V 366 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A & B PROVIDERS

Savin Grace , CEO [redacted], re-trained all staff on the timely reporting of all incidents within Savin Grace facility. All staff understand that responding and reporting all incidents are mandatory and that they fully understand their role in reporting all incidents. Savin Grace CEO created a incident log, to accommodate all incidences that occur on site and off site that involve any client placed in our care. The incident log will be kept in the incident log book and reviewed weekly by the Associate Professional, the Associate Professional will be responsible for ensuring that all incidents were entered into the IRIS reporting system and all parties were contacted. All incidents entered into the IRIS Reporting system will be printed and placed into the incident log book, readily available for review.

The Associate Professional shall send a copy of all level II incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident.

V537 27E .0108 CLIENT RIGHTS- TRAINING IN SEC REST & ITO

Each staff was trained in NCI Plus which included part A & B and passed with a score of 100% Savin Grace, CEO have contracted with Simpsons Training to ensure that all staff are trained in NCI Plus Part A & B prior to servicing any child placed in our care and annually thereafter.

V 736 27G .0303 © FACILITY AND GROUNDS MAINTENANCE

Savin Grace, CEO hired a contractor to make necessary repairs noted within the site deficiencies, on April 18th 2022 the closet door in reference to Client #1 room was placed on track, the wood molding around the ceiling was repaired. The under bed drawer that was missing was removed due to damage that was not able to be fixed.
The painting of all rooms including the ceilings noted of the home began and will be completed by June 4, 2022

Client #2
The wood door frame is being repaired by a contractor and will be completed by June 4th, 2022

Client #3
Door was repaired on 4/18/22
Blinds were ordered and installed
The room is slated to be re-painted and completed by June 4, 2022, this will alleviate the black marker behind the head of the bed.

Living room
Blinds have been ordered and installed on 4/20/2022
Ceiling fan was ordered and installed on 4/11/2022
Light bulbs was replaced with new fixture

The black chair was removed from the facility on 4/11/22

Bathroom
The bathroom was painted on 5/5/2022
Rusted standing toilet tissue holder was thrown out
The rust around vents was cleaned and painted
Towel bar was installed in the bathroom on 4/7/22 giving time for paint to dry

Kitchen
Savin Grace, CEO contacted the landlord to repair missing floorboards, the given estimated time to repair this deficiency is May21, 2022

All noted deficiencies regarding the tag noted will be completed by June4, 2022, Savin Grace, CEO has already begun the process of getting the items repaired and will send photos of completed items as they are completed,

The CEO, [redacted] will do a monthly walkthrough to ensure that any items in need of repair are documented and completed in a timely manner. The staff of Savin Grace, will inform the CEO immediately and document any repairs noted. The CEO will have the its repaired in a timely manner within 72 hours.

Jacqueline Ben, CEO 5/14/2022

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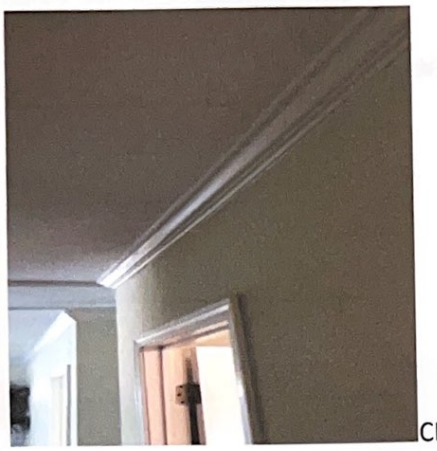

CEILING MOLDING REPAIRED

LIGHT FIXTURE IN BATHROOM REPLACED

LIVING ROOM LIGHT FIXTURE REPLACED

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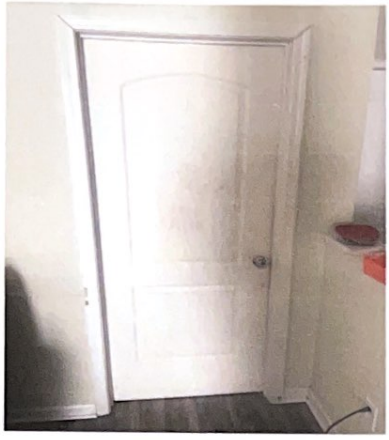

CLIENT #3 ROOM DOOR REPAIRED AND PUT BACK UP

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INCIDENT LOG

DATE OF INCIDENT	STAFF INVOLVED	DATE ENTERED INTO IRIS & LEVEL OF INCIDENT	EMS/POLICE CALLED	DATE REPORTED/ TO MH/DD/SA OFFICE	COMMENTS

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PSYCHOTROPIC MEDICATION REVIEW FORM

Pages 1 and 2 of this form MUST be completed for every appointment and attached to the consult sheet for review with the prescribing physician

Person's Name:	**Admission Date:**
Date of Birth:	**Age:**
Residential Provider:	**Residential Provider Contact: (919) 351-0465**
Physician's Name:	**Date of last quarterly Psychotropic Medication Review:**

CURRENT DIAGNOSES: Do not include diagnoses "by history," diagnoses that are resolved, or medical conditions that have resolved

Psychiatric Diagnosis	
Intellectual/Developmental Diagnosis	
Medical Diagnosis	

CURRENT MEDICATIONS: List all medications with dosages **OR** attach most recent Medication Administration Record (MAR) to this form

Medication	Dosage, Route, Frequency	Reason for medication

PSYCHOTROPIC MEDICATION CHANGES WITHIN THE LAST YEAR (*e.g.*, "Risperdone decreased from 3 mg per day to 2 mg per day")

Date	Medication Change	Reason for Change

ALLERGIES:

CURRENT WEIGHT:

HEALTH STATUS CHANGES AND MEDICATION SIDE EFFECTS since last medication appointment. Check all that apply (Click on box).

☐Activity level +/ - ☐Appetite + /- ☐Bruising ☐Constipation ☐Confusion ☐Diarrhea ☐Dizziness	☐Drooling ☐ Drowsiness ☐Dry mouth ☐Falls ☐Fever ☐Homicidal ideation/ behavior ☐Incontinence ☐Lethargy	☐Mental status deterioration ☐Muscle stiffness ☐Nausea/vomiting ☐Pain ☐Painful skin rash/ blisters ☐Seizures ☐Sleep changes +/-	☐Substance use- Alcohol ☐Substance use-Nicotine ☐Substance use-Illicit drugs ☐Suicidal ideation/ behavior ☐Swelling ☐Thirst	☐Tremor ☐Restlessness/inability to remain still ☐Weight changes + / - ☐Worsening of psychiatric symptoms ☐Other _____

CURRENT PSYCHOSOCIAL STRESSORS within the last six months. Check all that apply (Click on box). Include stressors that continue to affect the person even if the initial onset of the stressor was prior to 6 months ago.

☐	Abuse	☐	Health problems	☐	Pain/infection as a cause of behavior
☐	Educational problems	☐	Housing problems	☐	Parenting stress
☐	Occupational problems	☐	Financial problems	☐	Problems with primary support group
☐	Legal problems	☐	Grief/Loss/Separation	☐	Problems related to social environment
		☐	Issues with sexuality/ relationships	☐	Psychological trauma/Anniversary of trauma
					Other _____

Person's Name_____ **Date of Birth:**_____ **Appointment Date:**___

FREQUENCY OF TARGET BEHAVIORS over last 6 months:

Target Behaviors-Residential						

Target Behaviors-Day						

Describe target behaviors:

Check all incidents related to the person's mental health diagnosis or target behaviors since the last medication appointment and describe below: (Click on box).

☐ER/CPEP Visits ☐Psychiatric Hospitalization ☐Police ☐Physical Restraints ☐Property Damage ☐Suicide Threats

Describe incidents:

DAILY FUNCTIONING

Rate the person's participation in the following daily activities since the last medication appointment (Click on box).

Relating to Others				
1. Shows interest in socializing with others	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
2. Gets along with people he/she does not know well	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
3. Gets along with people who are close to him/her	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Life Activities				
4. Helps with household work	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
5. Is cooperative in work or day activities	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
6. Participates in activities or interventions to learn new skills	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
7. Adheres to a daily schedule (with or without assistance)	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Health and Safety				
8. Performs or cooperates with all self-care (e.g., eating, bathing)	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
9. Takes medications as directed	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
10. Maintains regular sleep patterns	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
11. Avoids dangerous situations	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Coping				
12. Manages strong emotions	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
13. Works cooperatively with others at home	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
14. Accepts help when it is needed	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Leisure and recreation				
15. Transitions easily from one activity to the next	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
16. Helps plan community activities for leisure or recreation	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Comments:				

Summary Completed By: (Signatures indicate that BEHAVIOR DATA AND PRIOR QUARTERLY REPORTS were reviewed in preparing this report.)

Printed Name/ Signature:	**Role:**
Printed Name/ Signature:	**Role:**
Date reviewed with team:	**Date reviewed with prescribing physician:**

Person's Name_____ **Date of Birth:**_____ **Appointment Date:**___

PSYCHOTROPIC MEDICATION REVIEW FORM
PHYSICIAN REPORT

(This page to be completed by prescriber of psychotropic medication)

This page can be completed for any appointment but MUST BE COMPLETED EVERY 90 DAYS MINIMUM

Psychiatric Diagnosis and Treatment Plan:

Treatment outcomes over past year: ☐ Unknown ☐Improved ☐No Change ☐Worse

Risks and benefits of current treatment:

Risks:	**Benefits:**

Is this risk present?	**No**	**Yes**	**Provide rationale for continuing medication if risk is present**	**Date medication education provided**
Off-label use?	☐	☐		
Black box warning issued?	☐	☐		
Medication side effects are observed?	☐	☐		
Symptoms of TD or other EPS are observed?	☐	☐		
Drug interactions are present?	☐	☐		
Medical contraindications are present (e.g. dementia-related psychosis?)	☐	☐		
Medication dosage is outside usual range?	☐	☐		
More than one medication from same drug class?	☐	☐		
Long term use of benzodiazepines?	☐	☐		

Gradual Dose Reduction: Has a gradual dose reduction been attempted in the last 3 months? ☐ YES ☐NO

If YES, outcome of the gradual dose reduction:_____

Is a gradual dose reduction appropriate at this time?

☐ **YES**, gradual dose reduction is appropriate at this time:

☐Recommended dose reduction (write new orders):

_____

☐**NO**, a gradual dose reduction is NOT appropriate at this time?

Reduction is NOT appropriate at this time due to: (check all that apply)

☐Previous attempt at reduction resulted in reoccurrence of behavioral symptoms (documented date: _____)
☐Reduction would likely impair this person's functioning or increase their distressed behavior:
☐Person continues to exhibit interfering target symptoms
☐Person is prescribed lowest effective dose necessary for stabilization

Clinical explanation for when a gradual dose reduction will be considered (e.g., what changes in behavior, mood, thought or functioning are evidence for gradual dose reduction?) _____

SIGNATURE INDICATES REVIEW OF ALL PAGES OF PSYCHOTROPIC MEDICATION REVIEW FORM AND PARTICIPATION IN PSYCHOTROPIC MEDICATION REVIEW			
Printed Name/Signature	**Date**	**Printed Name/ Signature**	**Date**
Prescriber:		**BSP Clinician:**	