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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			_			
		MHL060-157	B. WING		01/12/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDI			DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR OUT FEEL		YWOOD DRIVE			
INREACH	GREYWOOD DRIVE		TTE, NC 28212			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2023. A deficiency was	s completed on January 12, as cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 4 current clients.					
V 289	289 27G .5601 Supervised Living - Scope		V 289			
	10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which					
	illness but may also h (2) "B" designation	orimary diagnosis is mental ave other diagnoses; tion means a facility which primary diagnosis is a				
	developmental disabil diagnoses;	ity but may also have other tion means a facility which				

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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	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLI	=1ED	
		MHL060-157	B. WING		01/1	2/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INREACH	GREYWOOD DRIVE		WOOD DRIVE			
			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	(X5) COMPLETE DATE
	developmental disabi diagnoses; (4) "D" designa serves minors whose substance abuse dep other diagnoses; (5) "E" designa serves adults whose substance abuse dep other diagnoses; or (6) "F" designa	nendency but may also have ation means a facility which primary diagnosis is bendency but may also have tion means a facility in a				
	three adult clients wh mental illness but ma disabilities, or three a clients whose primary developmental disabilities who family provides the se exempt from the follor. 0201 (a)(1),(2),(3),(4 (A),(B),(E),(F),(G),(H) (18) and (b); 10A NCAC 27G .0208 (b),(e); 10 non-prescription med (1)(A),(D),(E);(f);(g); a (b)(2),(d)(4). This fact alternative family livin (AFL).	diult clients or three minor diagnoses is lities but may also have live with a family and the ervice. This facility shall be wing rules: 10A NCAC 27G),(5)(A)&(B); (6); (7)); (8); (11); (13); (15); (16); AC 27G .0202(a),(d),(g)(1))203; 10A NCAC 27G .0205 (G .0207 (b),(c); 10A NCAC A NCAC 27G .0209[(c)(1) - clications only] (d)(2),(4); (e) and 10A NCAC 27G .0304 cility shall also be known as ag or assisted family living				
This Rule is not met as evidenced by: Based on record reviews, observation and interviews the facility failed to provide services						

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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	
MHL060-157		B. WING		01/12/2023		
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	•		
INREACH	GREYWOOD DRIVE		/WOOD DRIVE TE, NC 28212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 289	Continued From page	2	V 289			
	within the scope of their license affecting 4 of 4 audited clients (#1, #2, #4 and #5). The findings are: Review of client #1's record on 1-5-23 revealed: Date of admission: 11-19-2013 Diagnoses: Mild Intellectual Disability Disorder, Downs Syndrome, Post Status Heart Transplant.					
	-Date of admission: 7 -Diagnoses: History of otherwise specified, (f Bi-Polar disorder not with psychotic features), ow) moderate severity,				
	Review of client #4's record on 1-5-23 revealed: Date of admission: 7-1-2001 Diagnosis: Mild Intellectual Disability Disorder					
	Date of admission: 9-	ectual Disability Disorder,				
	Record review on 1-1 Manager's (GHM) rec -Date of Hire: 5-9-201					
	1-9-23 at 12:30 pm re- no clients or staff we					
	-Had been the group approximately a year	ith the GHM revealed: home manager for and a half to two years. daughter) lived in the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	MHL060-157	B. WING		01	1/12/2023
NAME OF PROVIDED OR OURDING	•	I DDDDDDD OITY OTATE	710.0005	1 0	71272020
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE REYWOOD DRIVE	, ZIP CODE		
INREACH/GREYWOOD DRIVE		OTTE, NC 28212			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
with her in the facility -son and daughter in occasionallyclients were aware t lived in the facility. Interview on 1-12-23 -He was aware that t lived in the facility -son and daughter we sometimesson and daughter we sometimesson and daughter we them sometimes. Attempted interview to unsuccessful because interviewed. Observation on 1-12-revealed: -A young adult male aside door. Review of personnel Professional on 1-10 -Date of Hire: 9-9-20 -Hired as community	ent was part of her with the provider. For and 19 year old son lived of the tracted with the clients that the her son and daughter with Client #2 revealed: The GHM's son and daughter could eat with them (clients), could do activities with them could ride on the van with the with client #4 on 1-12-23 was the client did not want to be could record for the Qualified record for the Qualified record staff. The facility in 11-2022.	V 289			

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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	
MHL060-157		B. WING		01	01/12/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4922 GREYWOOD DRIVE						
INREACH	GREYWOOD DRIVE		TE, 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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 289	staff living in the facili -Clients were aware of daughter being in the -The clients "loved ha Interview on 1-10-23" revealed: -She was aware that daughter lived in the fi - Thought the licensed and not staff.	ty. If the GHM's son and facility. Iving children in the home." With the Program Director Ithe GHM and her son and facility. Ithe capacity referred to clients Inat addressed "live in staff Istaff and the live-in	V 289			

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