Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		D. WILLO				
		MHL047-175	B. WING		11/1	6/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CDACE	AND MEDCVIC	1443 STU	BBY OAKS I	ROAD		
GRACE	AND MERCY'S	ABERDE	EN, NC 2831	5		
(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 000	INITIAL COMMENT	S	V 000			
	on 11/16/23. The co	plaint survey was completed omplaints were substantiated 15 and #NC00209631). ited.				
		sed for the following service C 27G .5600F Supervised e Family Living.				
	This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.					
V 113	27G .0206 Client R	ecords	V 113			
	10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of					
	sudden illness or ac and telephone num physician;	ccident and the name, address ber of the client's preferred ent from the client or legally				

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL047-175	B. WING		11/1	6/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE A	AND MERCY'S		BBY OAKS I			
			EN, NC 2831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y 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 113	Continued From pa		V 113			
	emergency care from (7) documentation (8) documentation (9) if applicable: (A) documentation (1) diagnosis according (1) of Diseases (ICD-9) (1) documentation (1) documentation (1) documentation (1) each facility sharelative to AIDS or roonly in accordance	ers; ´ies of lab tests; and				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain client records affecting one of two clients (client #2). The findings are:					
	for client #2: -No documentation developmental disa diagnosis coded ac Statistical Manuel of	abilities or substance abuse coording to the Diagnostic and of Mental Disorders, ace sheet which includes: , middle, maiden); mber; d marital status;				

Division of Health Service Regulation

STATE FORM 6899 DFPF11 If continuation sheet 2 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			71. BOILDING.			
		MHL047-175	B. WING		11/1	6/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACE	AND MERCY'S		BBY OAKS I EN, NC 2831			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 113	the client granting p careNo emergency info shall include the na number of the pers sudden illness or and and telephone num physician. Interview on 11/15/2 Living (AFL) Provid -Client #2 moved in -She had no client in -Client #2 was not in didn't think a client	of a signed statement from permission to seek emergency ormation for client #2 which me, address and telephone on to be contacted in case of ecident and the name, address ber of the client's preferred 23 with the Alternative Family er revealed: 24 to her facility on 10/23/23. 25 receiving any services and she record was required for him. 26 facility failed to maintain a	V 113			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shad clients only when a client's physician. (3) Medications, incommodation administered only bunlicensed persons pharmacist or other privileged to prepart (4) A Medication Activity (2) A Medication Activity (3) Prescription (4) A Medication Activity (4) A Medication Activity (5) Prescription (6) Prescription (7) Prescription (7		V 118			

6899

Division of Health Service Regulation STATE FORM

DFPF11 If continuation sheet 3 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		MHL047-175	B. WING		11/1	6/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACE	AND MERCY'S		BBY OAKS I EN, NC 2831			
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	current. Medications recorded immediate 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 to checks shall be recorded.	s administered shall be ely after administration. The	V 118			
	interview, the facility were administered or physician and failed administered medic clients (#2). The fir Review on 11/15/23 for client #2: -No documented da-No documented di-No physician's ord milligrams (mg) (Se-No MAR for Octobous Observation on 11/10 pm of client #2's medical military medical me	on, record review and y failed to ensure medications on the written order of a I to maintain a MAR were rations affecting one of two ading are: Is revealed there was no record ate of admission. agnosis. er for Valproic Acid 250 eizure Disorder). er and November 2023.				

Division of Health Service Regulation

STATE FORM 6899 DFPF11 If continuation sheet 4 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		(X3) DATE COMP	SURVEY LETED
	MHL047-175	B. WING		11/1	6/2023
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AND MERCY'S	1443 STU	BBY OAKS I	ROAD		
AND INCITOT O	ABERDEE	N, NC 2831	5		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From pa	ge 4	V 118			
twice a day.					
Interview on 11/15/23 with the Alternative Family Living (AFL) Provider revealed: -Client #2 moved into her facility on 10/23/23Client #2 only take one medicationHe took Valproic Acid 2 times a day for SeizuresThey administered his medication for October and November 2023He had no physician's order for that medicationHe came from his mothers house with that medicationThey had not been documenting the medication was administered for client #2She did not know she was supposed to have a physician's order to administer that medication to client #2She also didn't know she was supposed to be documenting that medication was given on an MAR for client #2.					
V 289 27G .5601 Supervised Living - Scope 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.		V 289			
	PROVIDER OR SUPPLIER AND MERCY'S SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa twice a day. Interview on 11/15/2 Living (AFL) Provide -Client #2 moved in -Client #2 only take -He took Valproic A -They administered and November 202 -He had no physicia -He came from his medicationThey had not been was administered fo -She did not know s physician's order to client #2She also didn't know documenting that m MAR for client #2. 27G .5601 Supervise 10A NCAC 27G .56 (a) Supervised living provides residential home environment these services is the rehabilitation of indi illness, a development or a substance abu supervision when in (b) A supervised livit the facility serves ei (1) one or mo Minor and adult clies same facility.	MHL047-175 PROVIDER OR SUPPLIER STREET ADD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 twice a day. Interview on 11/15/23 with the Alternative Family Living (AFL) Provider revealed: -Client #2 moved into her facility on 10/23/23Client #2 only take one medicationHe took Valproic Acid 2 times a day for SeizuresThey administered his medication for October and November 2023He had no physician's order for that medicationHe came from his mothers house with that medicationThey had not been documenting the medication was administered for client #2She did not know she was supposed to have a physician's order to administer that medication to client #2She also didn't know she was supposed to be documenting that medication was given on an MAR for client #2. 27G .5601 Supervised Living - Scope 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	MHL047-175 MHL047-175 MHL047-175 STREET ADDRESS, CITY, STAND MERCY'S SUMMARY STATEMENT OF DEFICIENCIES, REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 twice a day. Interview on 11/15/23 with the Alternative Family Living (AFL) Provider revealed: -Client #2 moved into her facility on 10/23/23Client #2 moved into her facility on 10/23/23Client #2 moved into her facility on 10/23/23They administered his medication for October and November 2023He had no physician's order for that medicationHe came from his mothers house with that medicationThey had not been documenting the medication was administered for client #2She also didn't know she was supposed to be documenting that medication was given on an MAR for client #2. 27G .5601 Supervised Living - Scope 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.	OF CORRECTION MHL047-175 B. WING	MHL047-175 MHL047-175 MHL047-175 B. WING MHL047-175 B. WING 11/1 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1443 STUBBY OAKS ROAD ABERDEEN, NC 28315 SUMMARY STATEMENT OF DESTIGNATION (EACH DESTIGNATION MIST BE PRECIDED BY PULL REGULATORY ON LSC IDENTIFYING INFORMATION) Continued From page 4 twice a day. Interview on 11/15/23 with the Alternative Family Living (AFL) Provider revealed: -Client #2 only take one medication or October and November 2023He had no physician's order for that medicationHe came from his mothers house with that medication. -They had not been documenting the medication to client #2. -She did not know she was supposed to have a physician's order to administer that medication to client #2. -She also didn't know she was supposed to be documenting that medication was administered for client #2. -To 3601 Supervised Living - Scope 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 supervised living accidity 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.

Division of Health Service Regulation

STATE FORM 6899 DFPF11 If continuation sheet 5 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL047-175	B. WING		11/1	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GBACE	AND MERCY'S	1443 STU	BBY OAKS F	ROAD		
GNACE	AND MERCI 3	ABERDE	EN, NC 2831	5		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 5	V 289			
	licensed to serve a designated below: (1) "A" design serves adults whos illness but may also (2) "B" design serves minors whose developmental disadiagnoses; (3) "C" design serves adults whose developmental disadiagnoses; (4) "D" design serves minors whose substance abuse do other diagnoses; (5) "E" design serves adults whose substance abuse do other diagnoses; (6) "F" design serves adults whose substance abuse do other diagnoses; (7) "E" design serves adults whose substance abuse do other diagnoses; (8) "F" design serves adults whose substance abuse do other diagnoses; (9) "F" design serves adults whose substance abuse do other diagnoses; (10) "F" design serves adults whose substance abuse do other diagnoses; (11) "A" (12) (13) (13) (14) (15) (15) (15) (15) (15) (15) (15) (15	specific population as nation means a facility which e primary diagnosis is mental o have other diagnoses; nation means a facility which se primary diagnosis is a ibility but may also have other nation means a facility which e primary diagnosis is a ibility but may also have other nation means a facility which se primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility in a which serves no more than whose primary diagnoses is nay also have other adult clients or three minor				

Division of Health Service Regulation STATE FORM

DFPF11 If continuation sheet 6 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE COMP		
		MHL047-175	B. WING		44/4	6/2022
			<u> </u>		1 11/1	6/2023
NAME OF I	PROVIDER OR SUPPLIER		BBY OAKS I	STATE, ZIP CODE		
GRACE A	AND MERCY'S		EN, NC 2831			
(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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 6	V 289			
		acility shall also be known as ving or assisted family living				
	interviews, the facili adult clients did not	et as evidenced by: ons, record reviews and ity failed to ensure minor and reside in the same facility clients (#1 and #2). The				
	-Date of Admission -Diagnoses of Atter	ntion- Deficit Hyperactivity e Mood Dysregulation Disorder efiant Disorder.				
	Review on 11/15/23 for client #2: -No documented da -No documented da -No documented da	agnosis.				
	revealed: -The facility was lice	B of the facility's license ensed as a 5600F-Supervised e Family Living (AFL) with a s effective 1/1/23.				
	pm of the facility rev -Clients #1 and #2 v the facility.	15/23 at approximately 4:30 vealed: were sitting in the den area of both had separate bedrooms				

Division of Health Service Regulation

STATE FORM 6899 DFPF11 If continuation sheet 7 of 11

Division of Health Service Regulation

DIVISION	or ricallit Service INC	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	MHL047-175		B. WING		44/4	6/2023
		WHE047-175			11/1	0/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GDACE	AND MERCY'S	1443 STU	BBY OAKS I	ROAD		
GINACL	AND MILITOT 5	ABERDEE	N, NC 2831	5		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
V 289	Continued From pa	ge 7	V 289			
	with their own perso	onal belongings.				
		nor client residing with client				
	#2 an adult client.	G				
	Interview on 11/15/	23 with the Qualified				
	Professional reveal					
		e AFL Provider had a minor				
	and adult living in h	er facility.				
		to the AFL Provider's facility				
	on 10/23/23.					
		ntion on 10/27/23 through				
	someone from anot					
		was told she could not have a				
	minor and adult in t	ne same facility.				
	Interview on 11/15/2	23 with the Chief Operating				
	Officer revealed:					
		11/6/23 that an adult male				
		in the AFL Provider's facility				
	with an adolescent					
		#2 moved into the AFL				
	Provider's facility or					
		was told she was not an adolescent and adult in the				
	same facility.	in addlescent and addit in the				
	Samo faointy.					
	Interview on 11/15/2	23 with the AFL Provider				
	revealed:					
	-Client #1 was 17 ye school.	ears old and was still in high				
		cally living with me as a family				
	friend right now."					
		itted to her facility on 10/23/23				
	and he was 47 year					
		approved for a long term care, ot currently getting any				
	funding for him.	or currently getting any				
		oney for him, "I was not going				
		al Disability person out on the				

streets."

Division of Health Service Regulation

STATE FORM 6899 DFPF11 If continuation sheet 8 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL047-175	B. WING		11/1	6/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE A	AND MERCY'S		BBY OAKS F N, NC 2831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
V 289	-Client #2 was not r -They are trying to 'services" through th Entity/Managed Ca -Client #2 needed sand physical therap -Client #2 "really ca -She thought it was facility because he services. -She confirmed the	receiving any services. I'expedite for him to get the Local Management re Organization. Bervices, he needed speech	V 289			
V 539	10A NCAC 27F .01 ENVIRONMENT (a) Each client sha (1) an atmosyoninterrupted sleep hours, consistent work provided and the ty (2) accessible for at least limited produced inapprohabilitation team. (b) Each client shath his room, or his porwith respect to chois and with respect for restrictions on this fraccordance with go	Il be provided: phere conducive to during scheduled sleeping ith the types of services being pe of clients being served; and e areas for personal privacy, periods of time, unless priate by the treatment or Il be free to suitably decorate tion of a multi-resident room, ce, normalization principles, r the physical structure. Any freedom shall be carried out in verning body policy.	V 539			

6899

Division of Health Service Regulation STATE FORM

DFPF11 If continuation sheet 9 of 11

Division of Health Service Regulation

DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL047-175	B. WING		11/1	6/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CBACE	AND MEDCVIC	1443 STU	BBY OAKS F	ROAD		
GRACE	AND MERCY'S	ABERDEE	EN, NC 2831	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
V 539	Continued From pa	ge 9	V 539			
		ity failed to provide accessible privacy, affecting one of two ndings are:				
	-Date of Admission -Diagnoses of Atter	ntion- Deficit Hyperactivity e Mood Dysregulation Disorder efiant Disorder.				
	pm of client #1's be -There was a came bedroom door.	15/23 at approximately 12:45 edroom revealed: era on the wall over the pointed towards client #1's bed.				
	-He got dressed an -He never really pai in the bedroom.	23 with client #1 revealed: d undressed in his bedroom. id any attention to the camera ow long the camera was in his				
	Living (AFL) Provid -The camera had b about 6 monthsThe reason there w bedroom was due t behavior (SIB)He bites and scrate -He took a spiral no with the metal partHe will also hit him -He had those beha months.	was a camera in client #1's to his issues with self injurious ches himself. Otebook and scratched himself aself. Eaviors twice in the last 6				
		#1 started with the behaviors is parents were sent to prison.				

-He had no documented history of SIB.

Division of Health Service Regulation

STATE FORM 6899 DFPF11 If continuation sheet 10 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE : COMPI	
MHI 047-175				4414	0/0000
	MHL047-175	•		11/1	6/2023
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACE AND MERCY'S		BBY OAKS I EN, NC 2831			
PREFIX (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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
from the SIB episor -The camera in clie onShe can see the for camera on her cell -No one else had a "not even [the AFL -Client #1 got dress bedroomShe put the camer keep him safe.	quire ant medical attention des. ent #1's bedroom was always ootage from the bedroom phone. ccess to the camera footage,	V 539			

6899

Division of Health Service Regulation STATE FORM

DFPF11 If continuation sheet 11 of 11