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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED			
		MHL0601496	B. WING		02/04/2025			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE				
GRIER HO	GRIER HOME #2 8212 SPRINGHEAD LANE							
ORIERTIC	/ML #2	CHARLOT	TE, NC 28215					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	An annual survey was completed on 2-4-25. Deficiencies were cited.							
		d for the following service 27G .5600F Supervised Family Living.						
This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.								
V 118	27G .0209 (C) Medica	ation Requirements	V 118					
	V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the drug.							

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

(X6) DATE TITLE

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPL	
		MHL0601496	B. WING		02/0	04/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GRIER HO	MF #2	8212 SP	RINGHEAD LAN	IE .		
GINILINII	JIVIL #2	CHARLO	TTE, NC 28215	5		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 118	Continued From page	÷1	V 118			
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation				
	failed to ensure that I	ew and interviews the facility MAR's were kept current and of 3 clients (Client #1, #2,		Provider will go through an imm and emergent Med Admin re-tra This will be completed within th 30 days.	aining.	By or before 3/20/2025
	-Admitted 4-12-2 -Diagnoses inclu disorder, Encephalop Developmental Disor -Review of physi Clonidine .1mg (millig 2-7-24, Lithium 300m daily 1-26-25, Trazad 2-7-24, Metformin HC Quetiapine ER 400m (behavior), Resperide tablets pm 1-26-25Review of Clien 2024- January 2025 i	de: Bipolar disorder, Autistic athy, Moderate Intellectual der. cian's orders revealed: grams) (behavior) once daily g (behavior) three times one 50mg once daily(sleep) CL 500mg twice daily 2-7-24, g once daily 2-7-24 one 2mg 1 tablet am 2 the #1's MAR's for November revealed: no signatures dication had been given		CCMS has a newly hired nurse will be implementing med admir refresher courses for all AFL prevery 6 months.	n	Ongoing, every 6 months
	-Admitted 2-28-2 -Diagnoses inclu Intellectual Developm	Client #2's record revealed: 1. de: Autism, Severe lental Disorder, Seizure I Urinary Incontinence,				

Division of Health Service Regulation

STATE FORM 6899 KX8N11 If continuation sheet 2 of 6

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _				
MHL0601496		B. WING	B. WING		02/04/2025	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
	8212 SPI	RINGHEAD LANE	≣			
GRIER HOME #2	CHARLO	TTE, NC 28215				
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 118 Continued From page	e 2	V 118				
Unspecified Insomnia -Review of Phys Fluoxetine 20mg (bel Guanfacine HCL ER twice daily, Olanzapin 24 twice daily, Baclof 15-25 three times dai 2mg 8-7-24 three tim (sleep) 8-7-24 once r 24 (seizure Disorder) acetate .2mg (inconti -Review of Clien 2024- January 2025 i indicating that the messince 1-16-25 on the Review on 1-30-25 or -Admitted 2-28-2 -Diagnoses inclu Disorder, Severe Inter Disorder, Pica, Attent Disorder, Pica, Attent Disorder mixed type, DisorderReview of Phys Carbamazine ER 300 daily 1-14-25, Lamotr tabs twice daily 1-14- (behavior) 1 tab three Amantadine 100mg (1-14-24, Gabapentin bedtime 1-14-25, Lev (hypothyroidism) 1 ta Diazepam 5mg (anxietab pm 1-14-25, Topin am 3 tabs pm 1-14-2 -Review of Clien 2024- January 2025 i	ician's orders revealed: havior) 8-7-24 once daily, 2mg (behavior) 1-15-25 he 10mg (antipsychotic) 8-7- len 5mg (muscle spastic) 1- lly, Risperidone Irritabilities) les daily, Trazadone 50mg hightly, Lorazepam 1mg 8-7- once daily, Desmopressin hence) 1-15-25 once daily. It #2's MAR's for November revealed: no signatures edication had been given January MAR. If Client #3's record revealed: Idion Deficit/Hyper Activity Intermittent Explosive Intermittent Explosive Ician's orders revealed: Image times daily 1-14-25, behavior) 1 cap twice a day 300mg (pain) 3 caps at othyroxine 50mg b twice a day 1-14-25, lety) 1/2 tab am and noon, 1 ramate 50mg (Pica) 2 tabs	V 118				

Division of Health Service Regulation

STATE FORM 6899 KX8N11 If continuation sheet 3 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL0601496	B. WING		02/0	4/2025	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST.	ATE, ZIP CODE			
GRIER HOME #2		RINGHEAD LAN TTE, NC 28215				
PREFIX (EACH DEFICIENT	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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	
Living provider reversity and gotten MAR's but the client MAR's but the client Interview on 2-4-25 Professional reveal -She had alreat Family Living provide would ensure that goes documented according to the documented accordi	5 with the Alternative Family aled: etting dinged for this." behind documenting the its all got their medication. with the Qualified ed: dy talked to the Alternative der about the MAR's and oing forward, all MAR's would curately. by and Grounds Maintenance 03 LOCATION AND REMENTS its grounds shall be exclean, attractive and orderly exert free from offensive et as evidenced by: on and interviews the facility and in a clean, safe, orderly om offensive odors. The	V 118	Provider sent photos to the QP to following day where the home work cleaned (dining room, outside doupstairs hallway). Provider will continue regular clesschedule for clients in bedroom #2, however, this behavior is not both clients' behavior support ple is a known behavior of theirs. Provill continue interventions outling those plans, as well as working QP and behavior specialists in a to combat undesired behaviors a subsequent smells.	eaning #1 & ted in ans and rovider ed in with the	2/5/2025 Current and ongoing	

Division of Health Service Regulation

STATE FORM 6899 KX8N11 If continuation sheet 4 of 6

Division of Health Service Regulation

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE S COMPL			
		MHL0601496	B. WING		02/0	4/2025		
NAME OF PI	ROVIDER OR SUPPLIER	8212 SPF		DRESS, CITY, STATE, ZIP CODE				
(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 736	Living Provider reveal -He regularly cleated bedrooms, but the cliethe floor. -The clients also -The bedframe has a second to be a second	with the Alternative Family	V 736					
V 752	EQUIPMENT (b) Safety: Each facil constructed and equipmensures the physical visitors. (4) In areas of texposed to hot water,	4 FACILITY DESIGN AND	V 752	Water temperatures are commuto AFL's as the listed range (100 This provider was re-trained and policy provided. An updated for been provided to the provider wange specifically listed.	0-116). d the m has	2/10/2025		
	failed to ensure that h	ns and interviews the facility not water was between 110 rees in areas were clients						
	-Kitchen sink wa -Half bathroom s -Upstairs bathroo	25 of hot water revealed: us 120 degrees. ink was 121 degrees. om sink was 120 degrees. om bathtub was 121						
	Interview in 2-4-25 wi	th the Alternative Family				 		

Division of Health Service Regulation

STATE FORM 6899 KX8N11 If continuation sheet 5 of 6

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Division of Health Service Regulation

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NAME OF P	ROVIDER OR SUPPLIER	8212 SPR		DRESS, CITY, STATE, ZIP CODE				
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE			
V 752	Living provider reveal -He did not realiz that hot. Interview on 2-4-25 w Professional revealed -Their policy said degrees. -They would mak adjusted immediately	ed: te the hot water could not be with the Qualified that it could be 120 the sure that the water was were unable to speak about	V 752					

Division of Health Service Regulation

STATE FORM 6899 KX8N11 If continuation sheet 6 of 6