STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601496	A. BUILDING: _____ B. WING _____	R-C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIER HOME #2	8212 SPRINGHEAD LANE CHARLOTTE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 7/8/25. The complaint was unsubstantiated (Intake # NC00230414). Deficiencies were cited. This facility is licensed for the following service catagory: 10A NACA 27G 5600F Supervised Living for Alternative 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 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews the Alternative Family Living (AFL) Provider failed to demonstrate knowledge, skills and ability required by the population served. The findings are: Review on 6/27/25 of videos (2) from the AFL Provider's cell phone revealed: Video #1 -Front view of client #3 with small shopping cart dressed in black t-shirt and black shorts, and back left side view of client #2, dressed in blue t-shirt, black jogging pant with white side stripe. Clients #2/#3 picking up toiletry items with the AFL Provider's voice heard giving instructions. Client #3 front view holding chocolate candy he had picked up and AFL Provider voice heard, "put that back." Only AFL's voice was heard. A type written caption read, "If you're new here, I'm a full-time caregiver to three adults living with Autism." -AFL Provider wearing gloves while cleaning bathroom sink, sitting and folding clothes, spraying down shelves, arranging in bin, organizing toiletry items on shelf, cleaning washcloth and other items inside and around tub area, and spraying down tub. -Unable to read some of the added type written captions which were grainy and illegible.	V 110		

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V 110	Continued From page 2 Video #2 -A type written caption that read, "If you're new here. My name is [AFL Provider] and I'm a full time care giver to three adults living with Autism. The question I get asked THE MOST is, 'how does the boys do around my 6 year old son..." -Front view of client #2, wearing green long-sleeved shirt, shorts and sneakers, sitting on a couch in the AFL facility with a male child wearing a blue sweat suit. A long sheet of paper is draped on client #2, the child had drawn on the paper and was instructing client #2 to draw. Client #2 had his right arm folded to his chest and left arm rested across his lap, making sounds, talking gibberish and sporadically laughing. The child gave client #2 the crayon and pushed the paper onto client #2's lap. Client #2 briefly held the crayon, dropped it and slightly pushed the paper away. The child tried retuning the crayon to client #2's hand, "I want you to write." A type written caption read, "They act like normal brothers!!!" -Unable to read some of the added type written captions which were grainy and illegible. Review on 6/27/25 of client #1's record revealed: -Admitted 4/12/23. -Diagnoses: Moderate Intellectual Disability; Encephalopathy, unspecified; Other Bipolar Disorder and Autistic Disorder. Review on 6/27/25 of client #2's record revealed: -Admitted 10/27/21. Diagnoses: Autism Spectrum Disorder; Intellectual Disability, Severe; Seizure Disorder; Unspecified Urinary Incontinence; Unspecified Insomnia. Review on 6/27/25 of client #3's record revealed: -Admitted 2/28/23.	V 110		

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V 110	Continued From page 3 -Diagnoses: Severe Intellectual Disability; Pica; Attention Deficit Hyperactivity Disorder, mixed type; Intermittent Explosive Disorder; Autism Spectrum Disorder. Interview on 6/27/25 with client #1 revealed: -Responded to questions asked by repeating the questions in a low whisper. Interview on 6/27/25 with client #2 revealed: -Nonverbal and unable to respond to questions. Interview on 6/27/25 with client #3 revealed: -Spoke incoherent gibberish and had difficulty responding to questions asked. Attempted interview on 6/30/25 client #1's Legal Guardian(LG)/mother with no return call prior to survey exit. Interview on 6/30/25 with client #2's LG/mother revealed: -Was aware of the AFL Provider's social media page because he called and informed her beforehand. -Recalled seeing her son in videos two times in the past year. -"...a few years ago he (AFL Provider) had [client #2] on one (video) and put a sticky face and I told him (AFL Provider) he didn't have to do that. -Shared the AFL Provider's posts with family that are not on social media. -Had not given written permission, had never been asked, and didn't know she needed to give written consent for the social media page. Interview on 6/30/25 with client #3's LG/mother revealed: -Was aware of the AFL Provider's social media page, followed, and was aware that client #3 was	V 110		

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V 110	Continued From page 4	V 110		

in videos on the page.
-Had seen client #3 in videos on the page, but was not aware of other clients."
-The AFL Provider's page was raising of awareness of taking care of clients with disabilities and did not have a problem with it.
-The AFL Provider had asked permission to show client #3 on the page but had never asked for a written consent.

Interview on 7/1/25 with Day Support Staff #1 for clients #2/#3 revealed:
-Followed the AFL Provider's social media page.
-Had seen clients (#2, #3) engaged with the AFL provider on the page.
-"... there's a few videos...he (AFL Provider) does a series on a day in the life...about 20 videos...maybe half have clients...showing them (clients) getting ready for their day."

Interview on 7/1/25 with Day Support Staff #3 for clients #1/#2 revealed:
-Followed the AFL Provider's social media page.
-Recalled seeing a video post of clients going somewhere with the AFL Provider, "and [client #3] looked at the camera and was smiling..."

Interviews with the AFL Provider on 6/27/25 and 7/2/25 revealed:
-Had a personal, private social media page which included videos of clients.
-"I can't just get off (social media) because I have over a thousand followers."
-"They (followers) love my healthcare content. I do cooking for the boys (clients)."
-Recalled that clients #2 and #3 were in videos on his social media page.
-Client #2's LG/mother encourages his post on social media, "because it spreads awareness of autism."

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V 110	Continued From page 5 -Had verbal consent from all the clients' (#1, #2, #3) legal guardians. -Did not have a written consent on file, in client's records and did not know this was necessary. -"I can create one (written consent), that's no problem." -Would work with oversight agency and LGs to get written consents in client files. Interview on 6/30/25 with the Qualified Professional revealed: -Had spoken with the AFL Provider about his social media page (6/27/25), had requested access to see the page and it's content. -Access to the AFL Provider's page was denied as it was his personal page and private. -Was aware the AFL Provider needed written consents. -"The consent (audio-visual, pictures) that is on file (client's record) is for Covenant (oversight agency) only and he (AFL Provider) knows that." -Would ensure written consents are put in client records.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;	V 112		

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V 112	Continued From page 6 (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have treatment plan with written consent or agreement by the client's guardian or responsible party affecting 1 of 3 clients (client #3). The findings are: Review on 6/27/25 of client #3's record revealed: -Admitted 2/28/23. -Diagnoses: Severe Intellectual Disability; Pica; Attention Deficit Hyperactivity Disorder, mixed type; Intermittent Explosive Disorder; Autism Spectrum Disorder. -12/1/24 client #3 treatment plan with no written consent or agreement by client #3's legal guardian which confirmed the guardian's involvement in the development of the plan and agreement with the services or supports to be provided.	V 112		

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V 112	Continued From page 7 Interviews on 6/30/25, 7/2/25 and 7/7/25 with the Qualified Professional revealed: -Was responsible for treatment plans, updates and signatures. -Was not aware the signature page of client #3's treatment plan was blank. -Had made attempts to contact and left messages for client #3's care manager (7/2/25 and 7/7/25) and was waiting to hear back from her. -Would ensure client #3's treatment plan included the signed consent of the legal guardian to confirm the guardian was involved in the plan development and agreed with the services provided.	V 112		
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:	V 118		

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V 118	Continued From page 8 (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 administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to ensure medications were administered on the written order of a physician for clients #1 and #3. The findings are: Review on 6/27/25 of client #1's record revealed: -Admitted 4/12/23. -Diagnoses: Moderate Intellectual Disability; Encephalopathy, unspecified; Other Bipolar Disorder and Autistic Disorder. -Physician order dated 3/24/25 for Trazodone 50 milligrams (mg) tablet (sleep)- Take one tablet very evening as needed for sleep. - Physician order dated 2/6/25 for Ondansetron 4 mg tablet (nausea, vomiting)-Dissolve one tablet on tongue every 8 hours as needed for nausea or vomiting. Observation on 7/2/25 at 9:27 am of client #1's medications revealed: - Ondansetron 4 mg was not available.	V 118		

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V 118	Continued From page 9 Review on 7/2/25 of client #1's MAR for April 1, 2025 through July 2, 2025 revealed: -Ondansetron 4 mg was not initialed as administered. Interview on 7/7/25 with the Pharmacist revealed: -If Trazadone is prescribed as needed for sleep, then it should be given as prescribed. -Although Trazodone is a mild medication, administering it daily "could lead to dependence and the patient may need it more" to achieve sleep. Review on 6/27/25 of client #3's record revealed: -Admitted 2/28/23. -Diagnoses: Severe Intellectual Disability; Pica; Attention Deficit Hyperactivity Disorder, mixed type; Intermittent Explosive Disorder; Autism Spectrum Disorder. -Physician order dated 7/11/24 for Invega Sustenna 234 mg Injection (bipolar, mood disorder)-Inject 1.5 milliliters intramuscularly every 30 days. Observation on 7/2/25 at 9:48 am of client #3's medication revealed: - Invega Sustenna 234 mg was available. Review on 7/2/25 of client #3's MAR for April 1, 2025 through July 2, 2025 revealed: -Invega Sustenna 234 mg was not administered for June 2025. -Invega Sustenna 234 mg was administered on 4/16/25 and 5/16/25. Interview on 7/7/25 with client #3's Pharmacist revealed: -Invega is used for bipolar, schizophrenia, mood disorders.	V 118		

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V 118	Continued From page 10 -The Invega had not been in short supply and not been on back order. -Client #3's current Invega prescription was delivered to the facility on 6/26/25. -The pharmacy had delivered the previous Invega prescription to the facility on 5/22/25. -The pharmacy was not responsible to administer the injection of Invega. -Since the facility had the Invega (delivered 6/26/25), it would be okay to administer the June dose to client #3. -The monthly administration of Invega should be continued to avoid having to "redo the loading dose (higher beginning dose before lowering medication to maintenance dose)." -Missing the Invega for 30 days should be ok and it would not be advised to miss more than 30 days. Interviews on 7/1/25 and 7/7/25 with Day Support Staff #1 revealed: -She was assigned support for client #3. -Client #3 was getting his Invega injection monthly. -She was told by the AFL Provider that the June 2025 Invega was on back order from the pharmacy. Interviews on 7/2/25 and 7/8/25 with the Alternative Family Living (AFL) Provider revealed: -Client #3 was administered the Invega injection on the 16th of every month. -Client #3 missed the Invega injection in June (2025) because "it was on back order." -The AFL Provider requested prescription from client #3's physician for the June Invega, "and when I got the script it was on back order." -"The pharmacy first said they didn't have the script, then I was told they didn't have it in stock." -"I let the doctor (client #3) know that he (client	V 118		

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V 118	Continued From page 11 #3) missed the dose (Invega) and I resumed the schedule for July 15th (2025)." -"This is the 2nd time he's (client #3) missed (Invega injection), he missed when he first came (2/28/23)..." -Did not have documentation of reason for the missed Invega dose or that he informed the doctor of client #3's missed Invega injection. -Had not scheduled with the nurse to administer the Invega injection and planned to wait until the week of 7/15/25 schedule the Invega injection. -The nurse worked 3rd shift and he would see what day she could administer the Invega injection, "I will take care of that today." Interview on 7/7/25 with the Qualified Professional revealed: -She was not aware client #3 had missed his June Invega injection. -She was aware that the AFL Provider had a nurse who came monthly to the facility to administer the Invega injection. -The QP and oversight agency were responsible for reviewing MARs. -Would assist with improving communication regarding MARs, reviews and client medications. Due to the failure to accurately document medication administration and not having a medication available, it could not be determined when and if Client #1 received his medication as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 119		

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V 119	Continued From page 12 REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation and interview the facility failed to dispose of medications in a manner that guards against diversion or accidental ingestion affecting 3 of 3 clients (#1, #2, #3). The findings are:	V 119		

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V 119	Continued From page 13 Observation on 7/2/25 at approximately 10:13 am of the facility's over-the-counter (OTC) medication revealed: -OTC ibuprofen had an expiration date on the label of 4/2025. Interview on 7/2/25 with the Alternative Family Living Provided revealed: -Was not aware the ibuprofen was expired. -Would discard the medication.	V 119		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to the date of hire for the Qualified Professional (QP). The findings are: Review on 6/30/25 the QP's personnel record revealed: -Hired 2/6/25. -No documentation the HCPR was accessed	V 131		

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V 131	Continued From page 14 prior to hire. Interview on 7/2/25 with the Human Resource (HR) Specialist: -Had just started in her position about 2 months ago. -Had checked the QP's personnel record, saw there was no record of the HCPR, "so I ran another one (7/1/25)." Interviews on 7/1/25 and 7/8/25 with the Qualified Professional revealed: -Did not realize there was no HCPR in her personnel record. --"We've had some changes in HR staff" and the HCPR done prior to hire could not be located.	V 131		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements	V 366		

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V 366	Continued From page 15 set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed;	V 366		

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V 366	Continued From page 16 (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level I incidents as required. The findings are:

Review on 6/27/25 of client #1's record revealed:
-Admitted 4/12/23.
-Diagnoses: Moderate Intellectual Disability; Encephalopathy, unspecified; Other Bipolar Disorder and Autistic Disorder.
-Screening dated 4/12/23, nonverbal, self-injurious behaviors (SIBs), physically aggressive, property destruction, emotional outbursts, stealing food.
-Individual Support Plan dated 9/1/24, SIBs, has injured others and property, too many choices can increase frustration and lead to aggression, occasions of unprovoked aggressive behaviors; at previous group home, destroyed bed frame, attacked staff and housemates were "scared to come out of their rooms."
-Crisis Plan dated 9/1/24, "when really mad...may throw things, break things, attack (scratching, biting) others...run head into a wall...rip clothes...have destroyed floors, doors, beds, and other things...will throw things out the window.
-There was not documentation to support the removal of client #1's door knob from his bedroom door.

Review on 6/27/25 of client #2's record revealed:
-Admitted 10/27/21.
-Diagnoses: Autism Spectrum Disorder; Intellectual Disability, Severe; Seizure Disorder; Unspecified Urinary Incontinence; Unspecified Insomnia.
-Behavioral Treatment Plan dated 3/13/23,

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V 366	Continued From page 18 "...disruptive behavior (yelling/screaming, kicking/hitting walls or doors, knocking things off table, throwing things), physical aggression (grabbing others, scratching others) and/or SIBs (hitting self in face)...elopement...Despite overall progress and due to the ongoing presence of target behaviors that place [client #2] ' s safety, as well as the safety of others, at risk, and that also interfere with [client #2] ' s social and adaptive functioning, behavioral consultation remains indicated." -Individual Support Plan dated 5/1/25, "needs extensive support to prevent emotional outburst...will wander out of the house (facility) if not properly supervised...has temper tantrums, yelling outburst awkward noises when he does not get his way...grabbing things and breaking them, being uncooperative with staff and peers...meltdowns, physical aggression, and SIBs." Review on 6/27/25 of client #3's record revealed: -Admitted 2/28/23. -Diagnoses: Severe Intellectual Disability; Pica; Attention Deficit Hyperactivity Disorder, mixed type; Intermittent Explosive Disorder; Autism Spectrum Disorder. -Screening dated 3/1/23, physical aggression, property destruction, elopement, head butt, pull fingernails and toenails off, history of seizures -Individual Support Plan dated 12/1/24, "inappropriate toileting behavior-...playing in/smearing feces...SIB...property destruction...Pica...elopement...inappropriate sexual behavior...will destroy property, bang on things, scream, clap loudly with his hands, head butt, stomp, run, throw myself on the floor, scratch/punch/bite/hit/kick/pinch others, walk/jump on the back of furniture and on tables, pull things off of the wall, shred my clothes, pull	V 366		

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on the clothes of others, and/or steal food from others...fecal smear, masturbate at inappropriate times and places, and attempt to touch women ' s breasts."
-Behavior Support Plan dated 7/1/24, "...has a high tolerance for pain...has worn a one-piece garment that limits access to his genital area to help minimize his problems associated with having bowel movements outside the toilet, including smearing/playing with feces. He has recently punched through his window in his room, breaking the glass."

Review on 6/27/25 of facility incident reports 4/1/25 to 6/27/25 revealed:
-5/4/25, Client #3 received stitches as a result of falling and hitting the side of the tub while having a seizures.
-No documentation involving destruction of property (client #1, #3), physical aggressions (client #1), SIBs (client #1, #2, #3), punching through glass window in his bedroom at the facility (client #3) as detailed in client plans.
-No documentation of client attempts to elope (client #3).
-No documented behaviors of client #1 locking door his bedroom door that resulted in the AFL Provider removing the doorknob from client #1's bedroom door to keep client #1 from trying to elope (April/May 2025).
-No documentation of client #3 punching through his bedroom window breaking class (2024).
-No documentation of client #1 throwing a portapotty out of his bedroom window, and hanging his body out his bedroom window.
-No level I incident report for for client #2's seizure activity, 4/1/25-6/27/25.
-No level I documentation of client #3's missed Invega Injection June 2025.

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V 366	Continued From page 20 Interview on 6/27/25 with the Local Management Entity Human Rights Office revealed: -Client #1 was locking his bedroom door, trying to get out through the window to leave the facility. -Facility had taken doorknob off but put it back on until the treatment plan could be updated. Interview on 7/1/25 with Day Support Staff #1 for clients #2 and #3 revealed: -One of client #2's goals was "elopement from staff" (dates unknown). -Was aware client #2 broke a window and did not know date. -Had not seen door knob removed from client #1's bedroom door. -Was aware that client #3 has a camera in his room. -The AFL Provider was responsible for documenting incidents. Interview on 7/1/25 with Day Support Staff #2 for client #1 and #2 revealed: -Was not aware of incidents involving clients in the facility. -"Incident reports are done by whoever saw the incident. I haven't done any so I guess it would be [AFL Provider]" who would be responsible. Interviews on 6/27/25 and 7/2/25 with the AFL Provider revealed: -Was responsible for completing and submitting incident reports. -Was not aware of what incidents should be documented. -Was unable to recall dates of incidents. -Did not do an incident report when client #3 broke his bedroom window (2024), because client #3 "did not cut himself and was not harmed." -Had a chair outside client #3's room "to calm him at night...I can't afford not to know when he	V 366		

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leaves his room" and there is a camera in client #3's room that is written in his treatment plan.
-When client #3 broke his window in 2024, "he (client #3) now knows that a trigger reaction for me so he will go to the window and bang on it to get my reaction."
-Did not document client #1 throwing a portapotty out his bedroom window and hanging his body out the window (upstairs).
-Took the door knob off client #1's bedroom door (April/May 2025) when client #1 starting throwing things out his window, "...he was locking me out...had to kick in the door...I was afraid he was going to fall out (window) one day..."
-Had requested to put plexiglass on client #1's window.
-"I was in my bedroom below (first floor) and looked up to see him (client #1) hanging out the window and he had locked the door to the room (bedroom) and I took his knob off.
-Client #1 had opened his window to get a reaction "and threw his shoes out; when he does that I make him go downstairs and get it."
-Client #1 had "hit and swung at me before (dates unknown).
-Client #3 had hit the Nurse Practitioner as she was doing his labs (date unknown).
-Client #3 had a seizure 7/2/25 and client #3 "has seizures about 2-3x and month."
-Client #2 had broken multiple bed frames, "at least 3...has behaviors with jumping on the bed when he is manic...will run around the room then jump on the bed."
-Had not completed an incident report for the client #3's missed Invega injection in June 2025.
-Client #2 "will get aggressive if he gets too annoyed..."
-Failed to attend to the health and safety need of individuals involved, determine the cause of the incident, develop and implement corrective

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V 366	Continued From page 22 action, develop and implement measures to prevent similar incidents and assigning persons to be responsible for implementation of corrections and preventive measures. Interview on 6/27/25 with the Qualified Professional (QP) revealed: -Client #3 breaking his window happened before she began working with the AFL Provider and she was not sure if the former QP documented the incident. -Was not aware incident reports were not completed. -Relied on the AFL Provider to keep up with documentation of incidents. -Planned to improve systems and training for documenting and keeping up with incident reporting.	V 366		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a clean and attractive manner. The findings are: Observation on 6/27/25 at approximately 8:54 am of the facility revealed: -The strong smell of a cleaning agent. - A small pot was simmering on stove in the kitchen.	V 736		

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V 736	Continued From page 23 Observation on 7/2/25 at approximately 9:00 am revealed: Interior of the facility: -A strong foul odor or urine and feces. -A medium, black trash can was in the hall at the top of the stairs, filled with soiled adult diapers. -In the upstairs hallway were several plastic bins (approximately 4) filled with clothing, laundry baskets (2), black and white drawstring trash bags, and piles of loose clothing were stacked in the hallway. -Spider webs across the outside of client #3's bedroom window. -Piles of loose clothing along the wall leading to bathroom used by clients. -Laundry room with clothing stack approximately 2 feet high in a corner, items of clothing strewn on the floor and piles (2) on top of the washer and dryer. Further observation on 7/2/25 at approximately 11:00 am revealed: Exterior of the facility: -Front porch gutter and back gutters in deck area with clumps of wet dead leaves, pine straw, twigs and small seedlings. -Spider webs across exterior windows (side of garage, upstairs bedroom windows (3) and window in kitchen on deck side) and door (back door from kitchen that goes to deck). -Wet broken down cardboard and an old mail box on wood stand were stacked on top of a black metal rack behind the 2 trash bins on the right side of the garage. -Outer doorframe to the deck had a large spider web with spider. -Spider webs were in the outside corner walls and light fixtures. -A broom with an wet furnace filter laid over it. -Back deck had planter filled with wet leaves and	V 736		

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V 736	Continued From page 24 wet cardboard box filled with trash. -Twin mattresses (2) were laying over the opening of a Jacuzzi. Clients #1, #2, and #3 were nonverbal and unable to to be interviewed about the upkeep of the facility. Review on 6/27/25 of the [Cleaning Agent Brand] Manufacture website revealed: -"[Cleaning Agent Brand] products should not be heated. Our products are meant to be used only for household cleaning purposes and they are safe when used as directed. In order to use them appropriately, please always read the label for proper usage instructions." Interview on 6/27/25 with the North Carolina (NC) Poison Control Nurse revealed: -Cleaning agents should not be used as an air freshener. -[Cleaning Agent Brand] is a household cleaner and "we (NC Poison Control) don't advise boiling any cleaning agents." -[Cleaning Agent Brand] is not supposed to be boiled. -[Cleaning Agent Brand] is an irritant; "irritating the lungs and for someone with asthma and COPD (Chronic Obstructive Pulmonary Disease); it (irritant) can exasperate these conditions." -[Cleaning Agent Brand] is an irritant to the skin. -Cleaning agents are not made to be boiled and are vaporized into the air when boiled. -Some people are more sensitive than others to the effects of irritants. -"We would never recommend using any product for a purpose for which it was not intended." -Boiling a cleaning agent is an irritant that can result in headaches, nausea, dizziness, coughing.	V 736		

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V 736	Continued From page 25 Interviews on 6/27/25 and 7/2/25 with the Alternative Family Living Provider revealed: -Was boiling a cleaning agent on the stove to help give the facility a fresh scent, mask smells related to client incontinence, and "I have a smearer (client that smears feces)." -Typically boiled the cleaning agent "about 1-2 times a week or whenever there is a bad bowel movement." -Boiling cleaning agent was "mostly water, about 80%." -Was not aware of the irritating effects of toxic fumes produced when boiling a cleaning agent. -Did not use the deck often and "clients don't go back there." -Would talk to the landlord about getting gutters cleaned and spraying for spiders. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the facility was not free from insects. The findings are: Observation on 7/2/25 at approximately 9:00-9:39 am revealed: -Ants crawling on Surveyor's arm, computer and	V 738		

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V 738	Continued From page 26 workbag. - Ant crawling in dining room area and on the dining room table. Clients #1, #2, and #3 were nonverbal and unable to be interviewed about insects. Interview on 7/2/25 with the Alternative Family Living Provider revealed: -The ants may have been attracted to something on the table, "this is where they eat (clients)." -The window in the dining room had been left open and the ants may have come in the window. -The Landlord usually comes to exterminate in the summer. -He would talk with the Landlord about to have the exterminator to come.	V 738		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation, record reviews and interview the facility failed to ensure that hot water was between 110 degrees and 116 degrees in areas where clients had access to hot water. The findings are:	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601496	A. BUILDING: _____ B. WING _____	R-C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIER HOME #2	8212 SPRINGHEAD LANE CHARLOTTE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 752	Continued From page 27 Review on 6/27/25 of client #1's record revealed: -Admitted 4/12/23. -Diagnoses: Moderate Intellectual Disability; Encephalopathy, unspecified; Other Bipolar Disorder and Autistic Disorder. Review on 6/27/25 of client #2's record revealed: -Admitted 10/27/21. Diagnoses: Autism Spectrum Disorder; Intellectual Disability, Severe; Seizure Disorder; Unspecified Urinary Incontinence; Unspecified Insomnia. Review on 6/27/25 of client #1's record revealed: -Admitted 2/28/23. -Diagnoses: Severe Intellectual Disability; Pica; Attention Deficit Hyperactivity Disorder, mixed type; Intermittent Explosive Disorder; Autism Spectrum Disorder. Observation on 7/2/25 at approximately 11:00 am-11:30 am of hot water revealed: -Downstairs half bathroom sink was 118 degrees. Clients #1, #2, and #3 were nonverbal and unable to speak about the hot water. Interview in 7/2/25 with the Alternative Family Living Provider revealed: -Was not aware of the water temperature. -Had increased the water temperature during a bathroom renovation and forgot to decrease. -Would make sure to decrease the water temperature and adjust in the appropriate range (110-116). This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601496	A. BUILDING: _____ B. WING _____	R-C 07/08/2025

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V 774	Continued From page 28	V 774		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on observation and interview the facility failed to have minimum furnishings for a client bedroom. The findings are: Observation on 7/2/25 at approximately 10:00 am-10:30 am revealed: -Client #3's bedroom did not have a bed. -The mattress, pillow and bedding were on the floor in the middle of the bedroom Interview on 6/4/25 with the Alternative Family Living (AFL) Provider revealed: -Client #3 had broken bed frames multiple times, "at least 3." -Client #3 had behaviors of jumping on his bed when in his manic phase, "he (client #3) will run around the room then jump on the bed." -The mattress was not sitting directly on the floor, "it is sitting on top of 2 box springs".	V 774		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601496	A. BUILDING: _____ B. WING _____	R-C 07/08/2025

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V 774	Continued From page 29 -The thin box springs and mattress were not on a bed frame. -The AFL Provider was getting a prescription form the doctor to order a plastic bed.	V 774		