STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-058	A. BUILDING: _____ B. WING _____	R 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY ANGELS, INC - LAKEWOOD	302 GREENWOOD PLACE BELMONT, NC 28012

(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 An annual and follow up survey was completed on 3-7-18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability.	V 000	DHSR - Mental Health APR 19 2018 Lic. & Cert. Section	
V 139	27G .0404 (F-L) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (f) DHSR shall conduct inspections of facilities without advance notice. (g) Licenses for facilities that have not served any clients during the previous 12 months shall not be renewed. (h) DHSR shall conduct inspections of all 24-hour facilities an average of once every 12 months, to occur no later than 15 months as of July 1, 2007. (i) Written requests shall be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Construction of a new facility or any renovation of an existing facility; (2) Increase or decrease in capacity by program service type; (3) Change in program service; or (4) Change in location of facility. (j) Written notification must be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Change in ownership including any change in partnership; or (2) Change in name of facility. (k) When a licensee plans to close a facility or discontinue a service, written notice at least 30	V 139		

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HOLY ANGELS, INC - LAKEWOOD	302 GREENWOOD PLACE BELMONT, NC 28012

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V 139	Continued From page 1 days in advance shall be provided to DHSR, to all affected clients, and when applicable, to the legally responsible persons of all affected clients. This notice shall address continuity of services to clients in the facility. (l) Licenses shall expire unless renewed by DHSR for an additional period. Prior to the expiration of a license, the licensee shall submit to DHSR the following information: (1) Annual Fee; (2) Description of any changes in the facility since the last written notification was submitted; (3) Local current fire inspection report; (4) Annual sanitation inspection report, with the exception of a day/night or periodic service that does not handle food for which a sanitation inspection report is not required; and (5) The names of individuals who are owner, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity. This Rule is not met as evidenced by: Based on interviews the facility failed to completed the required emergency relocation information with the Division Of Health and Human Services (DHSR). The findings are: Interview on 3-7-18 with staff #1 revealed: -She knew that the clients had to be relocated for a few days, but their were no problems. Interview on 3-7-18 with staff #2 revealed: -One of the clients came to her on January 7 and told her that there was water in her bathroom.	V 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 139	Continued From page 2 -When she went in to look, she saw the bathroom was flooded. -She called the maintenance man, and he came quickly, but there was water a couple of inches deep in the room. -She got the clients out and then went back in for some clothes for them and their medications. -They moved to a guest house on the main campus while repairs were being made. -All the clients had their own bed, no one missed any medications, and there were no problems. -The clients enjoyed the time they spent there. Interview on 3-7-18 with the Qualified professional revealed: -The facility had a pipe burst in January and parts of the house were flooded. -They had to move all the clients to a guest house that the licensee has on the main campus. -All clients had their own bed, all medications were given. -The clients enjoyed the time and one called it a vacation. -She did not fill out an emergency relocation form and was not aware she needed to. Interview on 3-7-18 with the Chief Clinical Officer revealed: -She did not know that they were supposed to fill out an emergency relocation form. -They did inform all of the guardians -There were no issues with the relocation and the guest house was on the main campus. -In the future, they would be sure to notify DHSR if there was ever another emergency relocation	V 139	Holy Angels has familiarized itself with all information relative to this mandate as posted on NC DHSR website. At the time of the relocation Holy Angels ensured all elements referenced in 10A NCAC 27G .0404 were met. It was the completion and submission of the form titled Emergency Relocation of Clients that was omitted as this form is not referenced in 10A NCAC 27G.0404. All administrative personnel have been informed of the requirements relative to this form to avoid future omissions if/when residents are relocated from their home. Information and instructions regarding the completion of this form has been added to Holy Angels internal Policy and Procedure manual to ensure completion when applicable. Internal monitoring will be provided by Holy Angels Chief Clinical Officer on a quarterly basis.	Completed on 3/12/18 Completed on 3/12/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

March 15, 2018

Ms. Regina Moody, President/CEO
Holy Angels, Inc.
6600 Wilkinson Blvd.-PO Box 710
Belmont, NC 28012

Re: Annual and follow up Survey completed 3-7-18
Holy Angels, Inc.-Lakewood
MHL # 036-058
E-mail Address: reginam@holyangelsnv.org

Dear Ms. Moody:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 3-7-18.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- A Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 5-7-18.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
WWW.NCDHHS.GOV
TEL 919-855-3795 • FAX 919-715-8078
LOCATION: 1800 UMSTEAD DRIVE • WILLIAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 704-596-4072.

Sincerely,

Patricia Work

Patricia Work
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Cc: W. Rhett Melton, Director, Partners Behavioral Healthcare LME/MCO
Selenna Moss, Quality Management Director, Partners Behavioral Healthcare LME/MCO
Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File