PRINTED: 07/06/2018
FORM APPROVED

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
	MHL026-933	A. BUILDING: _____ B. WING _____	R 07/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTS OF HOPE HOME PLACE	1808 CONOVER DRIVE FAYETTEVILLE, NC 28304

(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 July 5, 2017. Deficiencies were cited. This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living For Adults with Developmental Disabilities.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including:	V 105	RECEIVED JUL 12 2018 DHSR-MH Licensure Sect Remotes next page →	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheryl A Lyons RN MSN — TITLE: QP — (X6) DATE: 7/12/18

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V 105	Continued From page 1 (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice of the use of a Glucometer	V 105	See notes next page →	

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V 105	Continued From page 2 Instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver for 1 of 3 audited clients (#3). The findings are: Review on 07/05/18 client #3's record revealed: - Her blood sugar was checked before breakfast and 2 hours after dinner. Interview on 07/05/18 client #3 stated: - Staff checked her blood sugar two times a day using a Glucometer Instrument. Interview on 07/05/18 the Qualified Professional stated: -She was aware of the requirement for obtaining a CLIA certificate for the facility and was in the process of completing the application. Interview on 5/25/18 the Qualified Professional Supervisor stated the facility and sister facilities were included on the Licensee's CLIA certificate. Interview on 5/25/18 the Executive Director stated she believed the Licensee's CLIA certificate included the facility. She understood the requirement to have a current CLIA certificate in order to use a Glucometer Instrument.	V 105	Sheryl A Lyons RN MAQP responsible party CLIA Application in process measures to correct deficiency Check on status of application To prevent problems in future request early enough to get response back in time of services needed. Responsible party will monitor the situation to ensure it will not occur again 3 months prior to renewals I will send out requests. 7/6/18	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff	V 114		

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V 114	Continued From page 3 and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 07/05/18 of facility records from September 2017 through July 2017 revealed: -Fire drills conducted 01/06/18 at 2pm and 04/06/18 at 2pm only. -No fire drills documented for fourth quarter 2017 (10/17, 11/17, 12/17). -Disaster drills conducted 10/26/17 at 5pm and 04/06/18 at 2:15pm only. -No disaster drills conducted first quarter 2018 (01/18, 02/18, 03/18). Interview on 07/05/18 client #2, #3 and #4 stated they had parucipated in fire and disaster drills at the facility. Interview on 07/05/18 staff #1 stated: -The facility only has two staff. -Each staff works 7 days on and 7 days off. -She had done fire and disaster drills. Interview on 07/05/18 the Qualified Professional (QP) stated: -Staff #1 and staff #2 were the only staff for the	V 114	See notes next page	

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V 114	Continued From page 4 facility. -The staff worked 7 days on and 7 days off. -She would make a calendar for the facility to schedule and complete fire and disaster drills. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	Calendar Schedules are completed and reviewed with Staff #1 & #2. to ensure proper use of Fire & Disaster drill practice.	7/12/18
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. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;	V 289		

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V 289	Continued From page 5 (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to operate within the scope of licensure by serving one of three audited clients (#2) without a primary diagnosis of Developmental Disability. The findings are:	V 289	See notes next page	

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V 289	Continued From page 6 Review on 07/05/18 of Division of Health Service Regulation (DHSR) records revealed the facility is licensed under 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities. Review on 07/05/18 of client #2's record revealed: - 46 year old female. - Admission date of 09/01/12. - Diagnoses of Schizophrenia-Pamoid Disorder and Bipolar Disorder. -Client #2's record did not reflect a diagnosis of developmental disability. Interview on 07/05/18 client #2 stated she had resided at the facility for several years. Interview on 07/05/18 the Qualified Professional (QP) stated: - She did not have a current waiver for client #2 to remain at the facility. - She was in the process of working with the Local Management Entity/Managed Care Organization regarding a waiver for client #2.	V 289	New Waiver request for #2 Client was emailed to Patricia Bryant DHHS mark Payne Director 12/17 Vince Wagnor LME Was contacted, sent Waiver request regarding request for visit from LME I was informed to Send that request to Bill young @ Alliance MCO Waiting for response for Letter of Support requested so LME to provide to Mark Payne Director for Approval 12/17 Waiver request. 3/18. I will Contact Vince Wagnor for F/u of hold up. 7/12/18 Did Call left message 1-910-491-4820	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 9, 2018

Mailed 7/12/18
Faxed 7/12/18
Sheryl Lyons 8/14/18

Sheryl Lyons
PTP-Lisbon, Inc.
4132 Lisbon Road
Council, NC 28434

Re: Annual and Follow Up Survey completed 07/05/18
Hearts of Hope Home Place, 1808 Conover Drive, Fayetteville, NC, 28304
MHL #026-933
E-mail Address: JMHFoundation@hotmail.com

Dear Ms. Lyons:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 07/05/18.

As a result of the follow up survey, it was determined that some 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

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 08/04/18.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 09/03/18.

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.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
LOCATION: 1900 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919 715-8078

- 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.***

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 Wendy Boone at (252) 568-2744.

Sincerely,

Gloria S. Locklear
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
File