Division of Health Service Regulation

PRINTED: 07/06/2018 FORM APPROVED

AND PLAN	Y OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENYIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	etc. (1)	0.000 / mar / control	A. BUILDING:	A. BUILDING:	
		MHL026-933	B. WNG		R 07/05/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STAT	E, ZIP CODE	
HEADTS	OF HOPE HOME PLACE	1808 CC	NOVER DRIVE		
HEARTS!	OF HOPE HOME PLACE	FAYETT	EVILLE, NC 28304	4	
(X4) ID		TEMENT OF DEFICIENCIES	QI	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual and follow on July 5, 2017. Defici	up survey was completed siencies were cited.			
		l for the following category: C Supervised Living For ental Disabilities.			
V 105	27G .0201 (A) (1-7) G	overning Body Policies	V 105		
	written policies for the (1) delegation of mana operation of the facility (2) criteria for admissio (3) criteria for discharg (4) admission assessm (A) who will perform the (B) time frames for con (5) client record manage (A) persons authorized (B) transporting records (C) safeguard of record defacement or use by the (D) assurance of record authorized users at all (E) assurance of confid (6) screenings, which see (A) an assessment of the problem or need; (B) an assessment of which is (B) an assessment of the confidence (C) and confidence (C) and confidence (C) are	y responsible for each develop and implement following: gement authority for the and services; on; e; hents, including: e assessment, and inpleting assessment gement, including: to document; s; ds against loss, tampering, unauthorized persons; d accessibility to times; and lentiality of records.		RECEIVED 1 2 2013 DHSR-MH Licensure Sect	
	needs; and (C) the disposition, incli recommendations:			Scenotes next page	
ivision of Heal	The Service Regulation RECTOR'S OR PROVIDER/SU	PLIER REPRESENTATIVES SIGNATURE	: /	TITLE OO	(X6) DATE

10 3

STATE FORM

Division of	f Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL026-933	B. WNG		R 07/05/2018
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE	, ZIP CODE	
		1808 CO	NOVER DRIVE		
HEARTS C	OF HOPE HOME PLACE	FAYETT	EVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE
V 105	Continued From page	1	V 105		
	(A) composition and a	activities of a quality			
	(B) written quality ass	y improvement committee; surance and quality			
	improvement plan;				
	(C) methods for moni quality and appropria	toring and evaluating the			
	including delineation	of client outcomes and			
	utilization of services;		İ		
	(D) professional or cli	inical supervision, including aff who are not qualified			
	professionals and pro	ovide direct client services			
		y a qualified professional in			
	that area of service; (E) strategies for imp	roving client care;			
	(F) review of staff qua	alifications and a			
	determination made to treatment/habilitation	to grant			
	(G) review of all fatal	ities of active clients who			
	were being served in	area-operated or contracted			
	residential programs	at the time of death; lards that assure operational			
	and programmatic pe	erformance meeting			
	applicable standards	of practice. For this			
	purpose, "applicable	standards of practice" spetence established with			
	reference to the prev	ailing and accepted			
	methods, and the de	gree of knowledge, skill and her practitioners in the field;			
	care exercised by ou	nei praeduoriore in die neier			
					į
		en puidoneed but			
	This Rule is not me	t as evidenced by: riew and interviews, the			İ
	facility failed to deve	lop and implement adoption			
	of standards that as	sure operational and		1 - 1 - 2 - 1 - 2	. 5
	standards of practic	mance meeting applicable e of the use of a Glucometer		See notes next po	50 7

W99811

Division of Health Service Regulation

PRINTED: 07/06/2018 FORM APPROVED

	T OF DEFICIENCIES	(AZ) MOETINEZ CONCINCIO, ION		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMPLETED	
		MHL026-933	B. WING		1 225	R
		111122333			07/	05/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
HEARTS	OF HOPE HOME PLACE		OVER DRIVE			
	,	FAYETTEV	ILLE, NC 283	304		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG		SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD I		DATE
	<u> </u>			DEFICIENCY)		
V 105	Continued From page	2	V 105			
	, and the same of		1 100			
		he CLIA (Clinical Laboratory				
		nents) waiver for 1 of 3				
	audited clients (#3). T	ne findings are:				
	Review on 07/05/18 c	lient #3's record revealed:				,
		checked before breakfast				
	and 2 hours after dinn					
!				CL . LOI / C Pala	1.00	
	Interview on 07/05/18	client #3 stated:		Dheryly Lyons Con	MACA	
į		ood sugar two times a day		reformatible Dartuc	LIA	
j	using a Glucometer In	strument.		Shery A Lyons RNn responsible party Co Application in process measures to correct		
i	Internitory on 07/05/40	4h- 0 - 15-4 D- 6		Application in proces	,s	
ļ	stated:	the Qualified Professional		COC TO COVVE	2f- 1	
		requirement for obtaining		Medisuxes	İ	
		ne facility and was in the		de Ciclency Checko	`	
1	process of completing			a colication	\sim	
				Status of of	.~	
i				To Dievent problems	17.1	i
	V PS V	MARK MINES BOOKEN THE MEET OF		Consect Cerl	4	- 1
:		ne Qualified Professional		tuture 1 Equest	VP.	
!		facility and sister facilities		assurate get respon	BC	1
:	were included on the L	icensee's CLIA certificate.		erious of ser	VICES	- 1
:	Interview on 5/25/12 th	ne Executive Director stated		deficiency checkon status of application To prevent problems future request Cerl enough to get respon back in time of ser needed. Responsible	DOVA	y 1
	she believed the Licen			- Responsible	pai,	1
	included the facility. S			needed. Kesponsist Will monitor the Sit	112 hor	\
}	그리스 하다 경영에 가지 않는데 하는데 아들은 이번 경영에 되었다면 했다는 데이를 당시하다면 하다 하다.	current CLIA certificate in		111 monitor the se	Sicus	
1	order to use a Glucom			Will not	Jam	1
į				to acros	to	
V 114	27G .0207 Emergency	Plans and Supplies	V 114	will monitor the Sit to expure it will not again 3 months prior renewals I will seno requests.	d out	
į		525		LO TIME I MILL DOUG	, , ,	
į		EMERGENCY PLANS		renewices		
	AND SUPPLIES			requests.		, 1
į	(a) A written fire plan for			,	}-	7/11-
Ì		n shall be developed and				18/18
	shall be approved by the	ne appropriate local			į	, 1.0
:	authority. (b) The plan shall be m	nade available to all staff			1	
3	(b) The plan sital be in	idd dydnabie to an stan			i	

W99B11

Division	of Health Service Regu	llation			FOR	RMAPPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	ESURVEY
ANDFON	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:		PLETED
		MHL026-933	B. MNG_		0.7	R //05/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE ZIL CODE		700/2010
UEADTO	05 H005 H045 DL 405		NOVER DRIVE			
HEARIS	OF HOPE HOME PLACE		EVILLE, NC 28			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CTION	(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPR	ULD BE	COMPLETE
				DEFICIENCY	TO THINK	ONIE
V 114	Continued From page	3	V 114		***************************************	
	and evacuation proce	dures and routes shall be				
	posted in the facility.	eries and reaces snan be				1
i	(c) Fire and disaster d	Irills in a 24-hour facility				
	shall be held at least of	quarterly and shall be				1
İ		t. Drills shall be conducted simulate fire emergencies.				
		nave basic first aid supplies				
İ	accessible for use.					
İ						
į						
1	This Rule is not met a	is evidenced by:				
İ	Based on record review	w and interview the facility				
1		disaster drills held at least				İ
	quarterly and repeated findings are:	on each shift. The				
į	muligs are.					
į	Review on 07/05/18 of		į			
		gh July 2017 revealed:				
	-Fire drills conducted 0	11/06/18 at 2pm and			,	1
	04/06/18 at 2pm only. No fire drills documen	ted for fourth quarter 2017				
	(10/17, 11/17, 12/17).	to a local departer so !)				
		ted 10/26/17 at 5pm and				
	04/06/18 at 2:15pm on					
	-No disaster driis cond (01/18, 02/18, 03/18).	lucted first quarter 2018				
1	(0 11 10, 02 10, 001 10).					
	Interview on 07/05/18 /	Tire and disaster dnils at	Į Į			
	the facility.	with discussion willing dis				
	lahan iaus ar 07/05/40	-1-16 Ha -1-1-1-			4	
	Interview on 07/05/18 s -The facility only has tw					
	-Frie facility only has to -Each staff works 7 day				and the second	
200	She had done fire and	1,000			ì	
1		he Qualified Professional		Sec notes next p	age !	
	(QP) stated: -Staff#1 and staff#2 w	rere the only staff for the		300 1013	J	
	h Service Regulation	ore the only stall for the		I		

Ith Service Regulation

	Division	of Health Service Requ	lation			T GITTIN	AFFROVED
MHLU26-933 C. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIF CODE: HEARTS OF HOPE HOME PLACE 1808 CONOVER DRIVE HAYET LEVILLE, NC 28304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (BACH CORRECTIVE ACTION OF IOULD BE COMPLETED FOR PROVIDER'S PLAN OF CORRECTION OF IOULD BE COMPLETED FOR PROVIDER'S PLAN OF CORRECTION OF IOULD BE COMPLETED FOR PROVIDER'S PLAN OF CORRECTION OF IOULD BE COMPLETED FOR PROVIDER'S PLAN OF CORRECTION OF IOULD BE COMPLETED FOR PROVIDER'S PLAN OF CORRECTION OF IOULD BE COMPLETED FOR PROVIDER'S PLAN OF CORRECTION OF IOUR DRIVER IN THE PROPERTY OF IOUNG INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE							
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (BACH CORRECTIVE ACTION OF IOULD DE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE					AYE, ZIF CODE		
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (SIACH CORRECTIVE ACTION CHOULD BE COMPLETED FOR REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	HEARTS	OF HOPE HOME PLACE			804		
	PREEIX	(PACH DEFICIENC	Y MUST BE PRECEDED BY FULL	TAG	(SACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
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. V289 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 to serve a specific population as designated below. (1) one or more minor clients, or (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; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses.		facility. The staff worked 7 d She would make a c schedule and comple This deficiency constit and must be corrected 27G .5601 Supervised 10A NCAC 27G .560 (a) Supervised living provides residential so home environment who these services is the c rehabilitation of indivice illness, a development or a substance abuse supervision when in th (b) A supervised livin the facility serves eith (1) one or more (2) two or more Minor and adult client same facility. (c) Each supervised I licensed to serve a sp designated below: (1) "A" designal serves adults whose p illness but may also h (2) "B" designal serves minors whose developmental disabil diagnoses; (3) "C" designal serves adults whose p developmental disabil diagnoses; (3) "C" designal	ays on and 7 days off. alendar for the facility to te fire and disaster drills. Itutes a re-cited deficiency d within 30 days. d Living - Scope 1 SCOPE is a 24-hour facility which ervices to individuals in a nere the primary purpose of care, habilitation or duals who have a mental ttal disability or disabilities, disorder, and who require he residence. g facility shall be licensed if er. eminor clients; or adult clients. s shall not reside in the living facility shall be recific population as thon means a facility which primary diagnosis is mental ave other diagnoses; tion means a facility which primary diagnosis is a ity but may also have other tion means a facility which primary diagnosis is a ity but may also have other	V 114	Calendar Schedule are completed and reviewed with St #1 + #2. to ensu proper use of Fire Disaster drill prac	aff re-E-tie.	7/12/18

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Division of Health Service Regulation

PRINTED: 07/06/2018 FORM APPROVED

MHL026-933 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 8, wN0 ROT/05/2018 1886 CONOVER DRIVE FAVETEVILLE, NC 28304 FAVETTEVILLE, NC 28304 10, PROVIDER'S PLAN OF CORRECTION CONDUCTION C	AND DI AN DE CORRECTION INCIDENTIFICATION NI IMPUR		The Control of Control	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHLD26-933 NAME OF PROVIDER OR SUPPLIER BEARTS OF HOPE HOME PLACE CAG ID SUMMARY STATEMENT OF DEFICIENCIES 1886 CONOVER DRIVE				A. Boilbino		ρ .
MEARTS OF HOPE HOME PLACE FAYETTEVILLE, NC 28304 (X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG PROVIDER'S PLAN OF CORNECTION (PROFICE NOT NOT NOT NOT NOT NOT NOT NOT NOT NOT	MHL026-933			8. WNG		Voc.
CALID SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CRUSS REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PREFI	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	
CAG ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CAGNO PRETTY REGULATORY OR LSC IDENTIFYING INFORMATION) PREFTX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFTX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFTX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFTX CROSS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCESS REFERENCED TO THE APPROPRIATE CARCES REFERENCED TO THE APPROPRIATE CARCESS	UEADTC (DE HODE HOME DI ACE	1808 CONC	VER DRIVE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 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: 10 A NCAC 27G .0201 (a)(1)(2)(3),(4)(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(F); (8); (11); (13); (15); (16); (18) and (b); 10 A NCAC 27G .0202 (a)(b),(e); 10 A NCAC 27G .02025 (a)(b); 10 A NCAC 27G .0203; 10 A NCAC 27G .0205 (a)(b); 10 A NCAC 27G .0203; 10 A NCAC 27G .0205 (a)(b); 10 A NCAC 27G .0203; (a)(b); (a)(a)(b);); (a)(a)(a)(b); (a)(a)(a)(b); (a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(MEAR 15	of hope nome place	FAYETTEV	ILLE, NC 2830	4	
(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 .0202 (a),(d),(g),(f),(g),(f),(g),(g),(g),(g),(g),(g),(g),(g),(g),(g	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(FACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROP	D BE COMPLETE
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: 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.	V 289	(4) "D" designal serves minors whose substance abuse depother diagnoses; (5) "E" designal serves adults whose substance abuse depother diagnoses; or (6) "F" designal private residence, whose three adult clients who mental illness but madisabilities, or three a clients whose primary developmental disabilities who family provides the sexempt from the follo 0201 (a)(1),(2),(3),(4) (A),(B),(E),(F),(G),(H); (18) and (b); 10A NCAC 27G .0208 (b),(e); 10 non-prescription medical me	tion means a facility which primary diagnosis is sendency but may also have tion means a facility which primary diagnosis is sendency but may also have tion means a facility in a sich serves no more than ose primary diagnoses is y also have other dult clients or three minor y diagnoses is lities but may also have live with a family and the ervice. This facility shall be wing rules: 10A NCAC 27G 10;(5)(A)&(B); (6); (7) (3); (11); (13); (15); (16); AC 27G 0.0202(a),(d),(g)(1) 203; 10A NCAC 27G 0.0205 (G 0.0207 (b),(c); 10A NCAC A NCAC 27G 0.0209[(c)(1) - lications only] (d)(2),(4); (e) and 10A NCAC 27G 0.0304 cility shall also be known as ng or assisted family living as evidenced by: ew and interview, the facility in the scope of licensure by audited clients (#2) without a	V 289	Le nev t	Page

W99B∵

SATEMENT OF DEPOCHODERS (MT) PROVIDERS UPPLIERICLES ADDITION A BUILDINGS (MT) COMPLETED (COMPLETED	Division of	ivision of Health Service Regulation				0.0000000000000000000000000000000000000
NAME OF PROVIDER OR SUPPLIES NAME OF PROVIDER OR SUPPLIES THE ADDRESS. CITY, STATE, ZIT CLOCK 1808 CONOVER DRIVE FAYETTEVILLE, NC 28304 V.289 Continued From page 6 Review on 07/05/18 of client #2/s record revealed: - 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 was in the process of working with the Local Management Entity/Managed Care Organization regarding a waiver for client #2.	AND PLAN OF CORRECTION INFORMATION NUMBER					
HEARTS OF HOPE HOME PLACE XAN ID PREFIX SUMMARY STATEMENT OF DEPICIENCIES PATETTEVILLE NC 23304 PREFIX REGULATORY OR LOS IDENTIFYING INFORMATION TAG PREFIX TAG PROMIDER'S PLAN OF CORRECTION (FLACH CORRECTIVE ACTION SHOULD BE COMPLETE DEPICIENCY MUST BE PRECEDED BY TULL TAG TAG TAG TAG PROMIDER'S PLAN OF CORRECTION (FLACH CORRECTIVE ACTION SHOULD BE COMPLETE DEPICIENCY MUST BE PRECEDED BY TULL TAG REVIEW ON 07/05/18 of DIVISION OF Health Service Regulation (DHSR) records revealed the facility is licensed under 10A NCAC 27G. 5500C. Supervised Living for Adults with Developmental Disabilities. Review on 07/05/18 of client #2's record revealed:			MHL026-933	B. WING		ACCUPATION OF THE STREET AND ACCUPATION AS
SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES SECRET DEPICIENCY MUST BE PRECEDED BY FULL TAG CROSS REFERENCED TO THE APPROPRIATE COMPLETE CO			*****		NTE, ZIP CODE	
V289 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 dient #2's record revealed the facility is licensed under 10A NCAC 27G. 5600C. Supervised Living for Adults with Developmental Disabilities. Review on 07/05/18 of dient #2's record revealed: -46 year old female4 dmission date of 09/01/12Diagnoses of Schizophrenia-Parnoid Disorder and Bipolar DisorderClient #2's record din or 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 facilityShe was in the process of working with the Local Management Entity/Managed Care Organization regarding a waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2 to remain at the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the facility of the professional (QP) stated: -She did not have a current waiver for client #2. The provided the professional (QP) stated: -She did not have a current waiver for client #2. The provided the professional (QP) stated the facility of the professional (QP	HEARIS	OF HOPE HOME PLACE	FAYETTEV	LLE, NC 283	04	
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ROY COOPER . Governor

MANDY COHEN, MD, MPH . Secretary MARK PAYNE - Director, Division of Health Service Regulation

July 9, 2018

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

Mailed 7/12/18

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 lattle. Below you will find details of the type of deficiencies found, the time frames for compfiance 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: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603 MAILING ADDRESS: 2716 Mail Service Center, Raleigh, NC 27699-2718 www.ncdhhs.gov/dhsr - TEL: 919-855-3795 - PAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

July 9, 2018 Sheryl Lyons PTP-Lisbon, Inc.

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

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.

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

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

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