PRINTED: 12/21/2018

DIVISION	of Health Service Re				FORM	I APPRO
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE S COMPL	URVEY ETED
······································		MHL026-933	B. WING	lists of an annual annu	R	
NAME OF F	ROVIDER OR SUPPLIER	SYREET	ADDRESS, CITY, STATE.	210 A.C.A.F	12/1	4/2018
HEARTS	OF HOPE HOME PLAC		NOVER DRIVE	zie Gripie		
		FAYETT	EVILLE, NC 28304			
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	aı	PROVIDER'S PLAN OF CORREC	TION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-RÉFERENCED TO THE ADDE	ULD BE	(X5) COMPLE
				DHSR FREMALL	JOANS I	DATE
V 000	INITIAL COMMENT	\$	V 000		realfu :	~
	A and a minimal no. 10 to			JAN 2 3 2019		
	on December 14, 20	ow up survey was completed 118. The complaint was		2019		
	unsubstantiated (inte	ake #NC00144689. A		lic & Cod Cod		
	deficiency was cited	·		Lic. & Cert. Section		
	This facility is the	and the same and the		· ^		
	This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living For Adults with Developmental Disabilities.		*	esonosible Party	. !	
.			Responsible Par Cheryl A Lyons V387 Patsy Priest C Incident Report Completed Via Oftempted to Pa LME CC told to		Sand as	
			4	very A Lyons A	WING COAL	
V 367	27G .0604 Incident Reporting Requirements		V 367	D int (ED		
į			10	itsy griter o	1	
	10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR			no Jant Reports	vere	
1	CATEGORY A AND B PROVIDERS		7	Win ha	nd	
į	(a) Category A and 8	3 providers shall report all	Cor	mpleted vin	26.6	
!	level II incidents, exc	ept deaths, that occur during	l ht	124-10		
-	the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall			at ac told-told	ell	
			1 4	TE CE TOBETO	1.101	
1			$ \mathcal{R} $	DHASK NOONE	COMER	
]				IN ME A CEX OF	-number	
			1 197	702.0		
ļ			DI	DHHSR NO ONE . VE. ME a fax or ere to send Re c LME was inf	POPS	
į !	oe supmitted on a for	M provided by the	اعر	of me was int	ormed	7_
1	Secretary. The report	may be submitted via mail,	1 1	Condrot-		
, , ,	u beizou' iacziwije di	encrypted electronic	1-2	of incidents.	و سس	2/
i i	neans. The report shall include the following information:			White with LM	I //c	×128/1
[(1) reporting pro	ovider contact and		of Meldents. when with LM unber land Con 10-491-4820	-	7
	dentification informati	on;	1 6	umber land con	*17 / I	
(client identification information;		n. 491-4820	it.	Inn!
	(3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified		191	10-411- 1000	17	21
					•	* +
					ļ	
1 1						
	r responding. b) Category A and R :	providers shall explain any				
n of Health	Service Remulation	7 /		etsteet	i	
ATORY DIR	ECTOR'S OR PROVIDER/SU	IPPLIER REPRESENTATIVES SIGNATURE		T)T) =		·····
		Ahra Atha		RNMAN	- 100 1 (X6)	DATE 7.2-1 G
FORM			9890 I2NK:1	1 4 = 0 - 1 1 LPC	100000000000000000000000000000000000000	101 L

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TATEMEN	of Health Service Regi			Total de manager par total		RMAPPROV
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL026-933		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		B. WING			R 12/14/2018	
ME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATIT 7/D (V)DE		11412018
EARTS	OF HOPE HOME PLACE	1808 CO	NOVER DRIVE	· · · · · · · · · · · · · · · · · · ·		
	TO T	FAYETTI	EVILLE, NC 283	SUV.		
(X4) ID	SUMMARY ST	ATEMENT OF DECICIENDIES				V
refix Tag	E SAVIT PERICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	TOM SHOW IN THE	(XS)
		•	ing	CROSS-REFERENCED TO 1	HE APPROPRIATE	DATE
V 367	Continued From page	> 1	V 367			
			V 307	Scenote		
!	shall submit an under	information. The provider		JOCK DIC		
į	roport rociniant an upoat	ed report to all required	l			
ĺ	day whenever:	e end of the next business				
!		had amana to to the				İ
-	information provided in	has reason to believe that	į			1
ļ	erroneous, misleading	or otherwise was be	į			
ì	erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable.					
İ				I.		
	(c) Category A and B providers shall submit.		1 1			İ
i	upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential					İ
						1
Ì						
	information:	.go morading confidential				
; i	(2) reports by oti	her authorities; and				İ
	(3) the provider's	response to the incident.	1			ł i
! ((d) Category A and B of	providers shall send a copy	1			ļ
1 1	or all level III incident le	eports to the Division of	1			
į 4	Mental Health, Develor	Omental Disabilities and				
	Substance Abuse Servi	ices within 72 hours of				
1 4	becoming aware of the	incident Category A				
- 1 4	providers shall send a c	CODY of all level III				
1 1	loidents involving a client death to the Division of]			
j t	realth Service Regulati	ion within 72 hours of				
	ecoming aware of the incident. In cases of dient death within seven days of use of seclusion or restraint, the provider shall report the death					
Ç						
i II	inneciately, as required	d by 10A NGAG SAG				
	0300 and 10A NCAC 2	7E .0104(e)(18).			İ	
3) !	Category A and B pr	roviders shall send a				
F6	spur quarieny to the Li	ME responsible for the			ļ	
7	atchment area where s	services are provided.				
	the Constitution	mitted on a form provided				
[D]	y une decretary via elec	ctronic means and shall				
; in	clude summary information	ation as follows:	-			
(1	medication em	ors that do not meet the				
	efinition of a level II or I	level III incident-	i		1	
(2	N	ventions that do not meet	I		1	

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PRINTED: 12/21/2018 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** (X3) DATE SURVEY A. BUILDING: __ COMPLETED MHL026-933 B. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEARTS OF HOPE HOME PLACE 1808 CONOVER DRIVE FAYETTEVILLE, NG 28304 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG PREFIX (X5) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 367 | Continued From page 2 V 367 the definition of a level II or level III incident; Sunte searches of a client or his living area; (4) seizures of client property or property in the possession of a client; the total number of level II and level III incidents that occurred; and a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 12/12/18 of the North Carolina Incident Response Improvement System IRIS) revealed: No documented level II incident reports (August 1, 2018 thru December 14, 2018.) Review on 12/12/18 of client #5's record revealed: - 61 year old female. - Admission date of 08/20/15. - Diagnoses of Schizophrenia, Hypertension,

Il incident reports for client #5 completed by the Division of Health Service Regulation

Syndrome.

Moderate Intellectual Disability, Morbid Obesity, Roscea, GERD (gastroesophageal reflux disease), History of Cerebral Palsy and Metabolic

Review on 12/14/18 of a copy of the facility's level

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Division	of Health Service Req	ulation			FORM APPROVED		
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIP	LE (X)NSTRUCTION			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X3) DATE SURVEY			
		1			COMPLETED		
		MHL026-933	B. WING		R		
NAME OF E	PROVIDER OR SUPPLIER			- por 10-1 00-10-10-10-10-10-10-10-10-10-10-10-10-1	12/14/2018		
			ADDRESS, CITY, S	TATH ZIP GODE			
HEARTS	of hope home place	1808 CC	NOVER DRIVE				
	·	FAYETT	EVILLE, NC 28	304			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		. ID	PROVIDER'S PLAN OF CORRECTION	ECTION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	I (EACH CORRECTIVE ACTION SHOULD	00		
		•	140	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	NATE DATE		
V 367	Continued From pag	e 3	V 367	1			
			V 367	1			
	QP (Qualified Professional) revealed: 08/17/18:		1	Su mote			
ļ	- "dislocation, broken	mulala fati	ŀ		İ		
	- Contact/Notification	of incidents 1 1					
İ	guardian/Aunt.	or incident: Legal	I				
1		stact to the LME/MCO (local					
	 No documented contact to the LME/MCO (local management entity/managed care organization). 				i		
	10/23/18:						
-	-"Cut, laceration, blee	dingfall Back of					
{	rorenead cut, bleeding	g, 1/2 inch in diameter,"					
İ	- Considering consum	ner d/c (discharge) from		·			
]	falling no longer mass	nability to ambulate without					
į	reming tro totifier tildet	s criteria for admission."					
į	Interview was not con	ducted with client #5 during			j		
ļ	the survey process du	e to client #5's					
ĺ	hospitalization/surgen	for gall bladder removal on	1				
\ \ !	11/29/18.		1				
į	Indus 4 American]				
į,	Interview on 12/12/18	and 12/14/18 the Group					
ì	Home Manager/Live-in	n Statt stated: I falls and she was not sure					
į,	why client #5 had falle	n and broke her ankle and					
; [1	required hospitalization	n and surgery (08/17/18) or					
<u> </u>	rell and received a cut	to her head and received					
	several stitches/suture	s (10/23/18).					
] -	 The QP was respons 	ible for completing the IRIS			į l		
	eports.]]		
١,	ntensiowe en 404646						
1 8	itated:	through 12/14/18 the QP					
, -		falls/injuries of unknown					
C	rigin since August 201	18.					
	Client #5 had surgery	due to the fall on 08/17/18					
{ a	ing required hospitaliza	ation and rehabilitation.	1				
-1	Client #5 fell again on	10/23/18 and was	1				
/ h	ospitalized and require	ed stitches/sutures to her					
	ead. She understood I avail	I II Tanalalana i					
h	e submitted to the tax	I II incident report should					
ision of Health	Service Regulation	E/MCO within the required					

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SIMICHEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) kar is wies en	P. P. a. P. C. C. A. A. A. A. A. A. A. A. A. A. A. A. A.		
MU H(W)	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED
MHL026-933 NAME OF PROVIDER OR SUPPLIER STREET		MHL026-933	B, WING	,	R	
		STREET	UDDRESS, CITY, STAT	דר אס בניתים	1 12	14/2018
EARTS (of hope home place		NOVER DRIVE	ing the court		
	- TOTAL PLACE		EVILLE, NG 2830	4		
(X4) ID PREFIX	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID I		DEFATION	
TAG	REGULATORY OR	PY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG URDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			CÓMPL DATE
V 367	- Ton pag		V 367			
	time, but had difficult system and had not o	y with the IRIS electronic contacted the LME/MCO.		Serve		
į	Interviews on 12/12/1 Licensee stated:	8 through 12/14/18 the		, , , , , , , , , , , , , , , , , , , ,		
	have fallen (08/17/18	the reasons for client #5 to , 10/23/18).				
1	 Client #5 required si enkle on 08/17/18 and required rehabilitation 	urgery for the fall/broken d was hospitalized and]
	-There were no decision client #5 from the faci	ions made to discharge lity,				
	-The completion of the responsibility of the Q	e IRIS reports were the P.				
;						
•						
:					ļ	
:						
ţ			1			