Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL084-085 04/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **109 PENNY STREET** LORETTA'S PLACE ALBEMARLE, NC 28001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 Premier Service of Carolina, Inc will ensure that 04/12/2019 all Healthcare Registries are check for any (Completed) A complaint survey was completed on 4/12/19. employee prior to employment. To ensure, this The following complaints were unsubstantiated: is completed, the Human Resources Department #NC150132, #NC150160, and #NC147931. The has included in named form, Verification of following complaint was substantiated: Background Form (See Attachment A), an #NC150019. Deficiencies were cited. area named asking to verify that the HealthCare Registry has been completed and incorporated This facility is licensed for the following service in the file category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility. V 131 G.S. 131E-256 (D2) HCPR - Prior Employment V 131 Verification **DHSR** - Mental Health G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY APR 25 2019 (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 Lic. & Cert. Section Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on records review and interview, the facility failed to access the Health Care Personnel Registry(HCPR) prior to hire for 1 of 7 staff (#3). The findings are: Review on 4/3/19 of staff #3's personnel record -hire date of 7/19/18 with job title of Residential Counselor: -HCPR was accessed on 2/1/19. Interview on 4/3/19 with the Human Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

-BSA Tropam Director

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL084-085 04/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **109 PENNY STREET** LORETTA'S PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 131 Continued From page 1 V 131 Resources(HR) Director revealed: -did not know why the initial HCPR check was not in staff #3's personnel record; -always do the HCPR checks prior to hire; -the HR Department moved to the new location; -may have been misplaced. V 314 27G .1901 Psych Res. Tx. Facility - Scope V 314 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting.

Division of Health Service Regulation

(e) The PRTF shall serve children or adolescents

community-based residential setting is essential

(g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation

for whom removal from home or a

(f) The PRTF shall coordinate with other individuals and agencies within the child or

to facilitate treatment.

adolescent's catchment area.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
MHL084-085 B. WING	04/12/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	04/12/2019	
LORETTA'S PLACE 109 PENNY STREET		
ALBEMARLE, NC 28001		
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V 314 Continued From page 2 of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure coordination of care with other individuals and agencies within the child or adolescent's catchment area affecting 1 of 3 audited clients (#1). The findings are: Review on 4/3/19 of client #1's record revealed: -admission date of 7/4/18 with diagnosis of Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder and Depressive Disorder; -in the custody of Social Services. Interview on 4/12/19 with client #1's Social Worker/Legal Guardian(SW/LG) revealed: -client #1's foster mother went for a scheduled appointment to the facility at 1:30pm on a Sunday; -it was a prearranged visit with client #1; -foster mother reported to SW/LG she got there, rang doorbell and got no answer; -foster mother reported she called the phone	gs directly (Complete the posted in will upervisor ts and/or	

Division of Health Service Regula	ation		FORM APPROVED
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/S

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY
		MHL084-085	B. WING			04/	12/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE			
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LOKETTA	SPLACE	ALBEM	ARLE, NC 28001				
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V 314	Continued From page	- 3	V 314				
	number she had and a foster mother called the sign in the door a foster mother banged response;	there was no answer; the phone number listed on	V 314				
	-police came, were no -foster mother was the staff came to the door -staff said they did no -another Social Worke Social Services was a	t hear anyone at the door ;					c
	was just placed at the -never been to this facture -had a prearranged vision -had arranged the visit at the facility; -when arrived at the facture -was able to open the the foyer area;	irst visit with a client who facility;					
	response; -called phone number foyer, it was not workir -pushed all the buttons -banged on the doors s -finally a staff came to another client; -the staff reported they floor and did not hear t -also staff reported the upstairs;	listed on the sign in the ng; s, called all the numbers; several times; the door with client #1 and were up on the second he banging or doorbell;					

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PRINTED: 04/17/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING_ MHL084-085 04/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **109 PENNY STREET** LORETTA'S PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 314 Continued From page 4 V 314 he reported her client was not here, he was on an outing with other staff; -staff called for her client to return to the facility for his scheduled visit: -was about 45 minutes to an hour before got a response from the staff from the time the foster mother arrived to the time the staff opened the door. Interview on 4/12/19 with client #1 revealed: -remembered when his foster mother came to visit him; -he, another client and staff were upstairs playing video games; -they did not hear the door bell ring or the phone -phone was not working upstairs; -someone kept banging: -police were there: -his foster mother picked him up for a visit: -not happened since. Interview on 4/12/19 with the Program Director and the Quality Assurance Director revealed: -not sure what happened: -usually the Residential Supervisor prints off all scheduled appointments and ensures weekend staff have the appointments. V 750 27G .0304(b)(3) Maintenance of Elec., Mech., & V 750 Water Systems 10A NCAC 27G .0304 FACILITY DESIGN AND **EQUIPMENT** (b) Safety: Each facility shall be designed.

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visitors. (3)

constructed and equipped in a manner that ensures the physical safety of clients, staff and

Electrical, mechanical and water

PRINTED: 04/17/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL084-085 04/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **109 PENNY STREET** LORETTA'S PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 750 Continued From page 5 V 750 systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure electrical, mechanical systems were maintained in operating condition. The findings are: Interview on 4/12/19 with client #1's Social Worker/Legal Guardian(SW/LG) revealed: -client #1's foster mother went for a scheduled appointment to the facility at 1:30pm on a -it was a prearranged visit with client #1; -foster mother reported to SW/LG she got there, rang doorbell and got no answer; -foster mother reported she called the phone number she had and there was no answer; -foster mother called the phone number listed on the sign in the door and it was notworking; -foster mother banged on the door and got no response; -foster mother became worried and called the police: -police came, were not able to get a response; -foster mother was there almost an hour before a staff came to the door: -staff said they did not hear anyone at the door; -another Social Worker(SW) from the same

Division of Health Service Regulation

was there.

Social Services was also there with the foster parent and can report what happened while she

-had a prearranged visit at 2:00pm on a Sunday;

Interview on 4/12/19 with SW revealed: -was going to do her first visit with a client who

was just placed at the facility; -never been to this facility before;

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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LORETTA	'S PLACE		Y STREET			
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		,	IAG	DEFICIENCY)		
V 750	C#	0	14750			
V / 50	Continued From page		V 750			
	-had arranged the visi	it through the case manager				
	at the facility;					
	-when arrived at the fa	acility, saw a foster mother				
	and a police officer;					
	-was able to open the	main door and go inside				
	the foyer area;					
	-rang bell, no answer,	called phone number, no				
	response;					
	-called phone number	listed on the sign in the				
	foyer, it was not worki	ng;				
	-pushed all the button	s, called all the numbers;				
	-banged on the doors	several times;				
	-finally a staff came to	the door with client #1 and				
	another client;			1		
	-the staff reported the	y were up on the second				
	floor and did not hear	the banging or doorbell;	-			
	-also staff reported the	e phone does not ring				
	upstairs;					
	-SW told staff she was	s here to visit with her client,				
		was not here, he was on an				
	outing with other staff;					
	-staff called for her clie	ent to return to the facility				
	for his scheduled visit;					
	-was about 45 minutes	s to an hour before got a				
		ff from the time the foster		*		
	mother arrived to the t	ime the staff opened the				
	door.					-
						-
I .	Interview on 4/12/19 w				71	- 1
		s foster mother came to				١
	visit him;	l -1-#				
		I staff were upstairs playing				- 1
	video games;	door hall since and have to			20	
		door bell ring or the phone				
	ring;	a unataira.				
	-phone was not working					
	-someone kept bangin	g;				
	-police were there;	and blooming for a collection				
	-his foster mother pick	ed nim up for a visit;				
	-not happened since.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL084-085	B. WING		04/12/2019		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 109 PENNY STREET ALBEMARLE, NC 28001						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
V 750	and the Quality Assur-had a new phone sys- upstairs phone numb- sign in foyer, forgot to new phone number o having issues with the	with the Program Director rance Director revealed: stem put in recently; per changed to call listed on change the sign with the n it in the foyer; he new system; he number, it rings upstairs	V 750	Premier has a new phone system in and the upstairs. The phone number sign has been changed to the newly phone number that rings directly up In addition, the main telephone num also been included. (See Attachme	or on the updated ostairs.		

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ATTACHMENT A



VERIFICATION FOR BACKGROUND/ HEALTHCARE REGISTRY

Employee:	s Address		
ast 4 digit			
Date of Bir	th:	5	
mm/dd/yy	/)	<u> </u>	
<u> </u>			
		RESULTS	
Da	te Results Request	Date	Complete:
ls t	the employee cleared to work:	Yes	No
An	y Disclosures of Convictions, which nee	eds to be explained	?
If s	o, has the employee completed the Disclos	sure for Criminal Con	viction form?YesNo
		If Applica	ble
	1. If employee was not cleared to work w	as a Post-Adverse Lette	r Sent?YesNo
	2. Date the Post-Adverse Letter sent or e	mailed? Date:	1
		HEALTHCARE REGIS	TRY
Dat	e Results Request:		Date Complete:
Elig	ible for Hire:		
Ver	ifier:		
	Authorized Personnel/Human Resource	5	Date

Created: 02/04/2019

Approved by: The Board of Directors/CEO/Authorized Personnel

ATTACHMENT B



CONSUMER APPOINTMENTS

Saturday 4/13/19 ATTACHMENT C 10:00AM **Sunday** 4/14/19 returns from TL Monday 4/15/19 Albemarle Peds (Wound Check) 8:30AM 10:00AM Mother will P/U Peds 2:00PM Tuesday Wednesday 4/17/19 Ped. 303 Yakin St. Albemarle NC 8:00PM Reg. Bivens Outpatient Yakin St. Albemarle NC4:30PM Thursday 4/18/19 Judicial Reviews 11:00AM Friday 4/19/19

Return Monday



