	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·	COMPLETED	
MHL026-933	B. WING		R <b>07/11/2019</b>	
HEARTS OF HOPE HOME PLACE	ADDRESS, CITY, ST DNOVER DRIVE EVILLE, NC 28	·		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	ΓE
V 000 INITIAL COMMENTS	V 000			
An annual and follow up survey was completed on July 11, 2019. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.				
V 114 27G .0207 Emergency Plans and Supplies	V 114			
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 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 interviews the facilit failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are:  Review on 07/10/19 of facility records revealed: - No documented fire or disaster drills from May 2018 thru December 2018 No documented disaster drill in the 2nd quarter				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y	
					R	
		MHL026-933	B. WING		07/11/2019	9
	PROVIDER OR SUPPLIER	1808 CON	DRESS, CITY, S IOVER DRIV VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	(5) PLETE ITE
V 114	Continued From pa	ge 1	V 114			
V 118	at the facility She understood the to be completed queshift She would complete the would complete the would complete the would ensure drills.	d some fire and disaster drills he fire and disaster drills had arterly and repeated on each ete drills as required.  19 the Licensee stated she were completed as required.	V 118			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shace clients only when a client's physician. (3) Medications, incommendation administered only builicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only builicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only builicensed persons pharmacist or other privileged to prepare (4) A Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of led to each client must be kept administered shall be ely after administration. The	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MIII 000 000	B. WING			₹
NAME OF	PROVIDER OR SUPPLIER	MHL026-933	1	STATE, ZIP CODE	07/1	1/2019
	OF HOPE HOME PL	1808 CON	IOVER DRIV	E		
		FAYETTE	VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 2	V 118			
	drug. (5) Client requests checks shall be red	for medication changes or corded and kept with the MAR appointment or consultation				
	Based on record reinterviews, the facil medications on the and failed to keep to fthree clients (#3)  Finding #1: Review on 07/10/19 revealed: - 71 year old female-Admission date or Diagnoses of Milo	f 01/12/96. I Mental Retardation, Bipolar Irenia, Diabetes, Hypertension				
	physician orders da - Losartan (lowers (mg) - take once da	•				
		9 of client #3's May 2019, June 9 MARs revealed the following take once daily.				

Division of Health Service Regulation

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
			A. BUILDING.		F	<b>)</b>
		MHL026-933	B. WING	·		1/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HEARTS	OF HOPE HOME PLA	ACF	OVER DRIV			
0.0.15	CLIMMADY CTA		VILLE, NC 2		ONI	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	- She had been to t	/19 client #3 revealed: he facility for many years. medications as ordered.				
	revealed: - 62 year old female - Admission date of - Diagnoses of Mild					
	orders revealed: - No order for Ciclo topically every day - No order Ammoni	of client #4's physician pirox (anti-fungal) - apply (toe). um Lactate 12% (treats dry, o the infected area as				
	July 2019 MARs re June 2019 - Ciclopirox - apply - Ammonium Lacta area as directed. - Staff initials to ind					
	July 2019 - No transcribed en - No transcribed en 12%.	try for Ciclopirox. try for Ammonium Lactate				
	medications revealed - Ciclopirox - apply 03/20/19).	10/19 at 11:30am of client #4's ed: topically every day (dated te 12% - unable to read label				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL026-933	B. WING		F 07/1	≀ 1/2019
	PROVIDER OR SUPPLIER	1808 CON	DRESS, CITY, S IOVER DRIV VILLE, NC 2		, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	directions.  Interview on 07/10/ - She used her lotic - She was provided prescriptions from h  Interview on 07/10/ - Client #4 was rece - She did not have a medicated lotions She would make a podiatrist to get pre  Interview on 07/10/ - She was aware th - She knew medicatin the facility.  Due to the failure to medication administ	19 client #4 stated: ons everyday. the medication lotion ner podiatrist.  19 staff #1 stated: ently admitted to the facility. any orders for client #4's en appointment with client #4's scriptions.  19 the Licensee stated: e MARs need to be current. tion orders had to be present of accurately document tration it could not be sereceived their medications	V 118			
V 133	G.S. §122C-80 CR CHECK REQUIRED APPLICANTS FOR (a) Definition As a "provider" applies to program and any po- developmental disal services that is liced Chapter. (b) Requirement A provider licensed un applicant to fill a po		V 133			

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STATE FORM 6899 21EJ11 If continuation sheet 5 of 11

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Division of Health Service Regulation

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		MIII 02C 022	B. WING		F 07/4	
		MHL026-933			07/1	1/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1808 CON	OVER DRIV	E		
HEARTS	OF HOPE HOME PLA	ACE	VILLE, NC 2			
	OUR MAA DV OTA		1			
(X4) ID		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
1710		,	17.00	DEFICIENCY)		
		_				
V 133	Continued From pa	ge 5	V 133			
	conditioned on con-	sent to a State and national				
		ord check of the applicant. If				
		een a resident of this State for				
		, then the offer of employment				
		onsent to a State and national				
		ord check of the applicant. The				
		story record check shall				
		he applicant's fingerprints. If				
		een a resident of this State for				
		then the offer is conditioned				
		te criminal history record				
		ant. A provider shall not				
		t who refuses to consent to a				
		ord check required by this				
		otherwise provided in this				
		ive business days of making				
		of employment, a provider				
		est to the Department of				
		114-19.10 to conduct a				
		ord check required by this				
		mit a request to a private				
		State criminal history record				
		his section. Notwithstanding				
		Department of Justice shall				
		national criminal history				
		mployment positions not				
	covered by Public L					
		lth and Human Services,				
		check Unit. Within five				
		ceipt of the national criminal				
		n, the Department of Health				
		es, Criminal Records Check				
		provider as to whether the				
	information receive	d may affect the employability				
		no case shall the results of the				
		story record check be shared				
		roviders shall make available				
		cation that a criminal history				
		mpleted on any staff covered				

Division	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		MHL026-933	B. WING			1/2019
					<b>U</b> 171	1,2010
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HEARTS	OF HOPE HOME PLA	ΔCF	NOVER DRIV			
,		FAYETTE	VILLE, NC 2	28304		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
17.0		,	17.0	DEFICIENCY)		
\/ 122	Continued From no	ago 6	V 133			
V 133	Continued From pa	ige 6	V 133			
	by this section. A co	ounty that has adopted an				
		dinance and has access to				
		ninal Information data bank				
		half of a provider a State				
		ord check required by this				
		provider having to submit a				
		artment of Justice. In such a				
		all commence with the State				
		ord check required by this				
		ousiness days of the employment by the provider.				
		information received by the				
		itial and may not be disclosed,				
		ant as provided in subsection				
		For purposes of this				
		n "private entity" means a				
		engaged in conducting				
		ord checks utilizing public				
		om a State agency.				
	(c) Action If an ap	oplicant's criminal history				
	record check revea	ls one or more convictions of				
		the provider shall consider all				
		tors in determining whether to				
	hire the applicant:					
		eriousness of the crime.				
	(2) The date of the					
	conviction.	person at the time of the				
		ces surrounding the				
	commission of the					
		een the criminal conduct of				
		job duties of the position to be				
	filled.	, 5 р 50 15 00				
	(6) The prison, jail,	probation, parole.				
		employment records of the				
		ate the crime was committed.				
		t commission by the person of				
	à relevant offense.	•				
	The fact of conviction	on of a relevant offense alone				

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Division of Health Service Regulation

AND BLAN OF CORRECTION INTERPRETATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		MHL026-933	B. WING			R 11/ <b>2019</b>
	PROVIDER OR SUPPLIER	1808 CON	DRESS, CITY, SIOVER DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 133	shall not be a bar to listed factors shall of the provider disques consideration of the provider may disclose the criminal history to the disqualification of the criminal history to the disqualification of the criminal history of the criminal history or employee of a procomplies with this socivil liability for:  (1) The failure of the individual on the bath the criminal history  (2) Failure to check criminal offenses if history record check criminal offenses if history record check criminal offenses if history record check criminal offenses in federal criminal history in federal criminal history. The federal criminal history is relevant offenses in federal criminal history in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history is relevant offenses in federal criminal history. The federal criminal history is relevant offenses in federal criminal history	o employment; however, the per considered by the provider. It is an applicant after a relevant factors, then the se information contained in record check that is relevant on, but may not provide a copy rry record check to the sy A provider and an officer rovider that, in good faith, ection shall be immune from the provider to employ an a sis of information provided in record check of the individual. It is an employee's history of the employee's criminal is requested and received in	V 133			

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DIVISION	of Health Service Re	eguiation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		MHL026-933	B. WING			1/2019
		WITIL026-933			07/1	1/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1808 CON	OVER DRIV	E		
HEARIS	OF HOPE HOME PLA	ACE FAYETTE	VILLE, NC 2	8304		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 133	Continued From pa	ae 8	V 133			
	•					
		ticle 16, Larceny; Article 17,				
		, Embezzlement; Article 19,				
		nd Cheats; Article 19A,				
		or Services by False or				
		Credit Device or Other Means;				
		ial Transaction Card Crime				
		uds; Article 21, Forgery; Article				
		st Public Morality and				
		A, Adult Establishments;				
		ion; Article 28, Perjury; Article				
		31, Misconduct in Public				
	1	Offenses Against the Public				
		Riots and Civil Disorders;				
		on of Minors; Article 40,				
		amily; Article 59, Public				
		ticle 60, Computer-Related				
		es also include possession or lation of the North Carolina				
		ces Act, Article 5 of Chapter				
		Statutes, and alcohol-related				
		ale to underage persons in				
		B-302 or driving while				
		n of G.S. 20-138.1 through				
	G.S. 20-138.5.	101 G.G. 20-100.1 tillough				
		ishing False Information Any				
		yment who willfully furnishes,				
		ise gives false information on				
		olication that is the basis for a				
		ord check under this section				
		Class A1 misdemeanor.				
		oloyment A provider may				
		at conditionally prior to				
		s of a criminal history record				
		e applicant if both of the				
	following requireme					
		all not employ an applicant				
		e applicant's consent for				
		ord check as required in				
		is section or the completed				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	<del></del>	F	,
		MHL026-933	B. WING	<del></del>		1/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HEARTS	OF HOPE HOME PLA	ACF	IOVER DRIV			
0(0) ID	CLIMMA DV CTA		VILLE, NC 2		ION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 9	V 133			
	(2) The provider sh criminal history reco business days after conditional employr 2001-155, s. 1; 200	required in G.S. 114-19.10. all submit the request for a ord check not later than five the individual begins ment. (2000-154, s. 4; 14-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.)				
	failed to request sta	views and interview the facility ate criminal back ground business days of employment of (#1 and Qualified				
	revealed: - Hire date: 08/01/1 - Job Title: Parapro - No state criminal					
	revealed: - Hire date: 05/01/1 - Job title: QP A statewide crimir 04/05/18 No state criminal business days of er	9 of the QP's personnel record 9. hal back ground check dated back ground check within five mployment at the facility. 19 the Licensee stated:				
	- Staff #1 had work years and should h	ed at the facility for several ave a statewide check.  Il staff needed a state criminal				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL026-933	B. WING		R <b>07/11/2019</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
UEADTO	OF HOPE HOME PLA	1808 CON	OVER DRIV		
HEARTS		FAYETTE	VILLE, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLÉTE
V 133	Continued From pa	ge 10	V 133		
V 133	-	ge 10 s within five business days of	V 133		

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