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PRINTED: 10/14/2019
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
	MHL002-028	A. BUILDING: _____ B. WING _____	R 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCA'S HOPE III	243 LILEDOUN ROAD TAYLORSVILLE, NC 28681

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V 000	INITIAL COMMENTS An annual, followup and complaint survey was completed on September 26, 2019. The complaint was substantiatedd (#NC00154873). Deficiencies were cited. This facility is licensed for the following service catetgory: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR	V 118	DHSR-Mental Health NOV 01 2019 Lic. & Cert. Section	

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V 118	Continued From page 1 file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure medications were administered as ordered for 1 of 3 audited clients (#2), failed to ensure MARs were current and that medications were only self-administered on the order of a physician for 3 of 3 audited clients (#1, #2, #3). The findings are: Client #1: Record review on 9/3/19 for Client #1 revealed: -Admitted on 10/23/17 with diagnoses of Mild Intellectual Disability, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Attention Deficit Hyperactivity Disorder, and Learning Disorder. -Physician's orders dated 5/18/19 for Depakote 500mg, one in the evening and Trazodone 50mg, one at bedtime. -No physician's order to self-administer medications. Review on 9/3/19 of the MARs for 6/2019-9/2019 revealed: -Administration of Depakote and Trazodone was not documented from 7/26/19-7/31/19. Interview on 9/3/18 with Client #1 revealed: -He received his medications daily. He knew that he took Trazodone and Depakote at night and indicated that he had never missed his nighttime medications.	V 118		

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V 118	Continued From page 2 -He stated that a staff member always administered his medications. Client #2: Record review on 9/3/19 for Client #2 revealed: -Admitted on 11/12/18 with diagnoses of Autism, Attention Deficit Hyperactivity Disorder, and Bi Polar Disorder. -Physician's order dated 5/8/19 for Lithium Carbonate 300mg, two in the morning and one at bedtime. -Physician's order dated 5/8/19 for Propranolol 10mg, one daily. -Physician's order dated 5/8/19 was for Latuda 60mg, one with dinner. The order was changed on 7/10/19 to 20mg at breakfast and 40mg with dinner. -No physician's order to self-administer medications. Review on 9/3/19 of the MARs for 6/2019-9/2019 revealed: -The PM dose of Lithium Carbonate was not documented as administered on 8/3/19. -The August and September MARs indicated the Propranolol dose was 20mg not 10mg. The dosed had been decreased on 5/8/19 but the August and September MARs were still showing the old dose. -The PM dose for Latuda was being administered at 8:00PM not with dinner. Interview on 9/3/18 with Client #2 revealed: -He received his medications daily. He took his Latuda at bedtime. -He stated that a staff member always administered his medications. -He had never missed taking any of his medications.	V 118		

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V 118	Continued From page 3 Client #3: Record review on 9/3/19 for Client #3 revealed: -Admitted on 10/24/18 with diagnoses of Attention Deficit Hyperactivity Disorder, Other Specified Bi Polar Disorder, Intermittent Explosive Disorder, and Oppositional Defiance Disorder. -Physician's order dated 5/8/19 for Depakote 500mg, one twice daily. -Physician's order dated 5/8/19 for Trazodone 50mg, one at bedtime. The order changed on 8/14/19 t0 50mg at bedtime as needed. -No physician's order to self-administer medications. Review on 9/3/19 of the MARs for 6/2019-9/2019 revealed: -The August MAR did not indicate the change to PRN (as needed). -The PM administration of Depakote was not documented on 6/17/19. Interview on 9/3/18 with Client #3 revealed: -He received his medications daily. He had never missed any medications. -He stated that a staff member always administered his medications. He had never given himself his mediations. Interview on 9/4/18 with the Director revealed: -She was responsible for the oversight of medication administration. -She wrote the MARs but at times some of the other staff helped with that. -She was usually the person responsible for updates to MARs. -Client #2 had always taken the Latuda at 8:00PM. Their dinner was usually at 6:00PM. -She had not realized that the several days in July	V 118		

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V 118	Continued From page 4 the Depakote and Trazodone had not been documented for Client #1. She confirmed that Client #1 had not missed any medications. -She kept her MARs on the computer and at the beginning of each month she would print new ones. She indicated that she had failed to change the Propranolol dosage on subsequent MARs for Client #2. -She stated that she tried to educate her clients about their medications. She wanted them to "know their meds." -She would have them sit down one at a time and she would pull out their medications. She then would have them read the label and pop out the medication into a cup, show it to her and then take their medication in front of her. She supervised this process. She would then put her initials on the MAR. -She felt this was a time of education for each client. This was a process that only she did with the clients. -She did not consider this self-administration and therefore did not have orders from their physicians. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118	Luca's Hope will ensure this will no longer happen by making Changes that involve the Director ensuring the mars are Checked on a weekly basis. STAFF will monitor each other upon Initializing the mar when they give meds. IF STAFF see missing Initials they will notify the supervisor Immediately Clients will no longer be allowed to pop their own medication, this will only be done by authorized staff. Director will ensure that all med Changes are updated on the mars.	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:	V 132		

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V 132	Continued From page 5 a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report an allegation of abuse by a staff member to the Health Care Personnel Registry. The findings are:	V 132		

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V 132	Continued From page 6 See V367 for additional information. Record review on 9/4/19 revealed no documentation of a report made to the Health Care Personnel Registry. Interviews on 9/4/19 and 9/20/19 with the Director revealed: -A report was made to the Department of Social Services (DSS) that FC #4 was being abused, specifically choked by a staff member. DSS came on site to investigate the allegation. DSS found no evidence of abuse. -After she learned of the allegation, she conducted her own investigation. She interviewed all the clients, met with staff, contacted the guardian. -FC #4 clearly stated the allegation was not true. -Neither she nor DSS found any evidence of abuse. -She indicated that she never had to do a report to the Health Care Registry before. -She was not aware of that procedure.	V 132	Luca's Hope will ensure this type of Incident will not happen again by Reporting all IF any Reports OR allegations are made regarding neglect to the health CARE Registry. The Director will be the one Responsible For ensuring this process Is Followed	
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during 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	V 367		

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V 367	Continued From page 7 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (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 or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III	V 367		

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V 367	Continued From page 8 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) 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 review and interview the facility failed to ensure Level II and III incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident effecting 1 of 1 client (#Former Client #4). The findings are:	V 367		

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V 367	Continued From page 9 Review on 9/3/19 of incident reports submitted into IRIS (Incident Reporting Improvement System) revealed no report for the incident on 6/23/19. Review of incident reports on 9/4/19 revealed: -On 6/23/19 "Staff engaged with client (FC #4) to get him to come in and eat dinner ...Client started cursing staff and walked up to staff (Staff #1) as he raised his arm like he was going to hit me. I stopped his hand from hitting me and held on to it and client feel down to the group yelling and rolling around on the ground. Client would not get up and I was afraid that he was going to hurt himself because he has his hands around his neck trying to choke himself ...I tried to keep him still because of the sticks, rocks and tree limbs that were on the ground. My hand was tangled in his shirt after he started trying to get out of it and it was hurting my hand. Another peer (Client #2) came out afterwards and he felt that I was getting hurt and he tried to help me because he could see my hand while client was out of control. Client kicked his peer very hard while screaming and yelling and this caused the other peer to try to protect himself by hitting his peer. Client finally got up and said that he was going to leave and would not come into the house. Client walked around the edge of the yard as if he was going to leave the premises and remained close to the road until the Director came back to talk to him ..." Interviews on 9/4/19 and 9/20/19 with the Director revealed: -A report was made to the Department of Social Services (DSS) that FC #4 was being abused, specifically choked by a staff member. DSS came on site to investigate the allegation. -She found no evidence of abuse by her staff	V 367		

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V 367	Continued From page 10 member and DSS unsubstantiated the allegation. FC #4 clearly stated the allegation was not true. -She failed to write up the IRIS report and submit it for this incident.	V 367	Luca's Hope will ensure that all Incidents are reported & submitted thoough the IRIS system. The Director will be Responsible For monitoring and ensuring that the Incidents are submitted within th 72 hour time Frame	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to	V 536		

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V 536	Continued From page 11 Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements:	V 536		

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V 536	Continued From page 12 (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.	V 536		

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V 536	Continued From page 13 (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 1 of 5 audited staff (#2) received initial training in alternatives to restrictive interventions and failed to ensure that 4 of 5 audited staff (#1, #3, #4, and the Qualified Professional) received the refresher training annually. The findings are: Review on 9/4/19 of the personnel record for Staff #1 revealed: -Hired on 2/23/17. -NCI (North Carolina Interventions) training that included alternatives to restrictive interventions on 1/30/18. No refresher training documented.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL002-028	A. BUILDING: _____ B. WING _____	R 09/26/2019

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V 536	Continued From page 14 Review on 9/4/19 of the personnel record for Staff #2 revealed: -Hired on 7/15/19. -No NCI training documented. No training in alternatives to restrictive interventions. Review on 9/4/19 of the personnel record for Staff #3 revealed: -Hired on 9/25/16. -NCI training that included alternatives to restrictive interventions on 8/13/17. No refresher training documented since that time. Review on 9/23/19 of the personnel record for Staff #4 revealed: -Hired on 7/25/18. -NCI training that included alternatives to restrictive interventions on 7/18/18. No refresher training documented since that time. Review on 9/4/19 of the personnel record for the Qualified Professional revealed: -Hired on 10/1/14. -NCI training that included alternatives to restrictive interventions on 8/13/17. No refresher training documented since that time. Interviews on 9/4/19 and 9/20/19 with the Director revealed: -NCI training had ended and the training she had once used was no longer available. -Three weeks ago, her prior trainer had informed her of a new training. -She had tried to find a replacement for NCI but didn't realized how long it had been. -She indicated there was a lapse in training for all staff. -She contacted her trainer about possible training during the survey. She had staff trained in the use of restrictive interventions and de-escalation	V 536		

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V 536	Continued From page 15 on 9/12/19.	V 536	Luca's Hope will ensure that all staff required training will be kept current and all staff will be given annual refresher train. Director will monitor the dates that training expires on a quarterly basis to prevent any lapse in trainings for staff	
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service	V 537		

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V 537	Continued From page 16 provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence	V 537		

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V 537	Continued From page 17 by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.	V 537		

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V 537	Continued From page 18 (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 1 of 5 audited staff (#2) received initial training in seclusion, physical restraint and isolation time-out and failed to ensure that 4 of 5 audited staff (#1, #3, #4, and the Qualified Professional) received the refresher training annually affecting 2 of 4 audited clients (#2, Former Client #4). The findings are: Review on 9/4/19 of the record for Former Client	V 537	Luca's Hope has already brought this Rule In Compliance by getting all staff trained. The Director will ensure that moving Forward staff will Recieve Refresher Classes on an annual basis in order to remain in compliance with this Rule. ~~Ch~~ staff Records will be monitored on a quarterly basis	

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V 537	Continued From page 19 #4 (FC #4) revealed: -Admitted on 5/6/19 with diagnoses of Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation. -Discharged on 8/27/19. -Age 14. -Comprehensive Clinical Assessment indicated FC #4 struggled with emotional regulation, making appropriate behavioral choices, and instigated arguments. Behaviors included yelling, cursing, threatening physical violence, instigated negative peer interactions, and verbal aggression. It was also noted that FC #4 could de-escalate with support. -Safety assessment indicated that FC #4 had a history of property destruction and fighting with others. Review on 9/4/19 of the record for Client #2 revealed: -Admitted on 11/12/18 with diagnoses of Autism, Attention Deficit Hyperactivity Disorder, and Bi Polar Disorder. -Age 17. -History of property destruction, non-compliance with rules, and physical aggression towards others. Review on 9/4/19 of the personnel record for Staff #1 revealed: -Hired on 2/23/17. -NCI (North Carolina Interventions) training on 1/30/18. No refresher training documented. Review on 9/4/19 of the personnel record for Staff #2 revealed: -Hired on 7/15/19. -No NCI training documented. Review on 9/4/19 of the personnel record for Staff	V 537		

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V 537	Continued From page 20 #3 revealed: -Hired on 9/25/16. -NCI training on 8/13/17. No refresher training documented since that time. Review on 9/23/19 of the personnel record for Staff #4 revealed: -Hired on 7/25/18. -NCI training on 7/18/18. No refresher training documented since that time. Review on 9/4/19 of the personnel record for the Qualified Professional revealed: -Hired on 10/1/14. -NCI training on 8/13/17. No refresher training documented since that time. Review of incident reports on 9/4/19 revealed: -On 6/23/19 "Staff engaged with client (FC #4) to get him to come in and eat dinner ...Client started cursing staff and walked up to staff (Staff #1) as he raised his arm like he was going to hit me. I stopped his hand from hitting me and held on to it and client feel down to the group yelling and rolling around on the ground. Client would not get up and I was afraid that he was going to hurt himself because he has his hands around his neck trying to choke himself ...I tried to keep him still because of the sticks, rocks and tree limbs that were on the ground. My hand was tangled in his shirt after he started trying to get out of it and it was hurting my hand. Another peer (Client #2) came out afterwards and he felt that I was getting hurt and he tried to help me because he could see my hand while client was out of control. Client kicked his peer very hard while screaming and yelling and this caused the other peer to try to protect himself by hitting his peer. Client finally got up and said that he was going to leave and would not come into the house. Client walked	V 537		

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V 537	Continued From page 21 around the edge of the yard as if he was going to leave the premises and remained close to the road until the Director came back to talk to him ..." Interview on 9/4/19 with Staff #1 revealed: -At one time she worked in the facility but now she worked in the office assisting the Director. On the date of the incident she was filling in with Staff #4. -On 6/23/19 she was outside with FC #4 directing him to come inside for dinner. He began to curse and yell and as she walked toward him he approached her with his hand raised like he was going to hit her. She indicated that she blocked him first then reached around and grabbed the back of his shirt with one hand. He dropped to the ground rolling around, kicking and screaming. She stated he was trying to choke himself and she was trying to grab his other hand to get it away from his neck. She was still holding on to his shirt and her hand was getting tangled in his shirt. She was able to get his hand to release from around his neck. FC #4 was still on the ground laying on his side and she continued to have a grip on his shirt and was attempting to hold one of his arms next to his side. -She indicated she "was trying to restrain" FC #4. -While FC #4 was still on the ground Client #2 engaged and was trying to grab the feet of FC #4. FC #4 kicked Client #2 multiple times and then Client #2 started hitting FC #4. Staff #4 intervened and got Client #2 calmed down. -FC #4 rolled onto his back and stood up. Her hand was still tangled in his shirt, but she got her hand free when FC #4 started running to the edge of the yard. He was walking on the edge of the yard when the Director arrived. -FC #4 had red marks on his neck and scrapes on his skin from being in the pine needles.	V 537		

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V 537	Continued From page 22 -She had not received any NCI training in 2019. Interview on 9/18/19 with Staff #4 revealed: -Client #2 had informed her that Staff #1 needed help outside with FC #4. -She indicated that Staff #1 was trying to get FC #4 to calm down. Staff #1 was holding onto his shirt and FC #4 had thrown himself to the ground. He was thrashing around on the ground, and her hand was tangled in his shirt. FC #4 was trying to choke himself and Staff #1 was telling him repeatedly to calm down. -When Client #2 began to hit FC #4 she "grabbed him" and put him in a "little hug". She was trying to keep his arms down and turn him away. Client #2 responded and turned away. -She indicated that they had been trained in restrictive interventions last week. Interviews on 9/4/19 and 9/20/19 with the Director revealed: -On 6/23/19 she was contacted by staff and when she arrived the altercation was over. FC #4 was sitting on the edge of the yard. -Staff #1 was trying to get him inside the house and FC #4 was mad because it was not his turn to pick out the movie to watch. He approached Staff #1 with his fist drawn. Staff #1 thought he was going to hit her. Staff #1 indicated that she had blocked his hand and grabbed his shirt. When FC #4 fell to the ground she was trying to get her hand loose from being twisted up in his shirt. When Client #2 engaged in the incident he hit FC #4 after being kicked. Staff #4 was able to get Client #2 under control. -Neither client was injured during the incident. -FC #4 had a history of hitting female staff. She observed red marks on his neck which he indicated were caused when he was trying to get out of his shirt during the incident. He told her he	V 537		

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V 537	Continued From page 23 didn't mean to hurt Staff #1's hand. -NCI training had ended and the training she had once used was no longer available. -Three weeks ago, her prior trainer had informed her of a new training. -She had tried to find a replacement for NCI but didn't realized how long it had been. -She indicated there was a lapse in training for all staff. -She contacted her trainer about possible training during the survey. She had staff trained in the use of restrictive interventions and de-escalation on 9/12/19. Review on 9/24/19 of the Plan of Protection completed and signed by the Director on 9/24/19 revealed: -"Luca's Hope will ensure that all required trainings are kept up to date and valid without lapse in the dates of certification, while adhering to the new safety plan. Luca's Hope has corrected the above violation by getting staff the required training EBPI (Evidence Based Protective Interventions) training on 9/12/19. Luca's Hope will perform quarterly training reviews to ensure that dates and validity of training are kept current." -"Luca's Hope will start a new practice that involves reviewing skills that staff have learned and how they should be implemented in the event that a client becomes angry, has an outburst and becomes threatening and physically aggressive. The home will conduct this review on a monthly basis during the mandatory staff meeting. Included in this review the clinician will review the following steps with staff that work directly with clients. 1. How to identify/assess the Safety/Risk Level a. What behaviors is the client using? Aggression, threats, property damage, emotional	V 537		

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V 537	Continued From page 24 outburst b. How much control/influence do you have with client? No control, some control, usually have no control 2. Most effective immediate safety action is to: a. Separate from client when he starts to escalate in anger; b. Do not engage with client if they don't won't to talk or join the group, not receptive; c. Calmly go to another area, leaving client space to calm down while continuing to monitor client to ensure their safety." FC #4 had a history of physical aggression towards peers and staff. Without proper de-escalation he would engage in physical fights with others. Client #2 also had a history of physical aggression. On 6/26/19, FC #4 became physically aggressive with Staff #1. She failed to implement a proper restraint and was unable to de-escalate FC #4. He tried to harm himself during the event and subsequently was aggressive toward Client #2 when he got involved. When Staff #4 intervened, she restrained Client #2 with an improper physical hold. Due to not having current training in restrrictive interventions, neither Staff #1 nor Staff #4 knew the proper responses to use with two clients whose behaviors escalated out of control. Failure to train staff in the use of restrictive interventions who work with clients who exhibit aggressive behaviors is detrimental to the health, safety, and welfare of clients and constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 537		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

October 15, 2019

Valarie Stanback, Director
Luca's Hope, LLC
PO Box 442
Sherrills Ford, NC 28673

Re: Annual, Follow up and Complaint Survey completed September 26, 2019
Luca's Hope III, 243 Liledoun Road, Taylorsville, NC 28681
MHL # 002-028
E-mail Address: valariestanback@yahoo.com
(Intake #NC00154873)

Dear Ms. Stanback:

Thank you for the cooperation and courtesy extended during the annual, follow up and complaint survey completed September 26, 2019. The complaint was substantiated.

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

- Type B rule violation is cited for 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time Out (V537).
- A re-cited standard level deficiency.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type B violation(s) must be ***corrected*** within 45 days from the exit date of the survey, which is November 10, 2019. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed deficiency by the 45th day from the date of the survey may result in the assessment of an administrative penalty of $200.00 (Two Hundred) against Luca's Hope, LLC for each day the deficiency remains out of compliance.
- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is October 26, 2019.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is November 25, 2019.

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.
- 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 Sonia Eldridge at 828-665-9911.

Sincerely,

Kem Roberts

Kem Roberts
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant