



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

October 23, 2019

Nadia Lightner, Qualified Professional
Praising Hands, LLC
5501 Executive Center Drive, Suite 223
Charlotte, NC 28212

RECEIVED

DEC 20 2019

DHSR-MH Licensure Sect

Re: Annual Survey completed October 18, 2019
The Threatt's Home, 111 Babbling Brook Road, Mooresville, NC 28117
MHL # 049-144
E-mail Address: nlightner@praisinghandsllc.com

Dear Ms. Lightner:

Thank you for the cooperation and courtesy extended during the annual survey completed October 18, 2019.

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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is December 17, 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.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

October 23, 2019
Nadia Lightner
Praising Hands, LLC

- 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 Barbara Perdue at (336) 861-6283.

Sincerely,



Sheri Spicer
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2019
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NAME OF PROVIDER OR SUPPLIER
THE THREATT'S HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**111 BABBLING BROOK ROAD
MOORESVILLE, NC 28117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on 10/18/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living or Assisted Family Living (AFL).	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 file followed up by appointment or consultation with a physician.	V 118		

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next page

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sandra Lloyd* TITLE *CEO* (X6) DATE *12/10/2019*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2019
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NAME OF PROVIDER OR SUPPLIER THE THREATT'S HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 BABBLING BROOK ROAD MOORESVILLE, NC 28117
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V 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications administered were recorded on each client's MAR immediately after administration affecting 1 of 1 audited clients (client #1). The findings are:</p> <p>Review on 10/17/19 of client #1's record revealed: -An admission date of 5/23/19; -Diagnoses included severe Intellectual Developmental Disability, Downs Syndrome, Hypothyroidism and Hyperlipidemia; -Physician's orders signed 7/24/19 for Fluoxetine (used to treat depression) 40 milligrams, 1 capsule daily, Cetirizine Hydrochloride (used to treat allergies) 10 milligrams, 1 tablet daily and Synthroid (used to treat hypothyroidism) 112 micrograms, 1 tablet daily.</p> <p>Review on 10/17/19 at 12:16 pm of client #1's MARs for October 2019 revealed: -Fluoxetine, Cetirizine Hydrochloride and Synthroid were scheduled to be administered at 9:00 am; -No documentation of administration for Fluoxetine, Cetirizine Hydrochloride and Synthroid on 10/17/19.</p> <p>Interview on 10/17/19 with the Provider revealed: -She had administered Fluoxetine, Cetirizine Hydrochloride and Synthroid to client #1 at 9:00 am; -She had always documented all medications administered throughout the day in the evening</p>	V 118	<p>At the time of the survey, the above referenced facility and consumer were transferred to another agency for services. The change of ownership documents were signed by all parties on 5/6/2019. Praising Hands received an email from DanaLouise Reeves on 5/9/2019 acknowledging receipt of the request for change of ownership. Per the email from DHHS - Praising Hands, LLC would be notified of a decision (approved or denied). At present, we have not received an answer from DHHS. The date of admission of the consumer in the home referenced for this survey is documented as 5/23/19. Our consumer was discharged on 1/17/2019. There has been no access to this home due to services being billed and monitored by Life Alliance and another MCO. (Partners Behavioral Health.) Praising Hands does not have a contract with Partners LME. In relation to the deficiencies sited in this corrective plan of action, PH hands is not authorized to supervise this placement. During the active period of providing services in the Threat home, the AFL provider did receive Medication Administration Training, which at present has expired. (8/19). Praising Hands has implemented the following to comply with DHHS policies and procedures by initiating the request for the termination of the Threat Home license effective 12/10/19 and mailing the license to the DHHS Mental Health Licensure Division. Please see attached supporting documentation. Termination Letter Threat License (copy) Change of Ownership signature page Change of Ownership acknowledgement (Danalouise Reeves) Client Discharge form and authorization Threat Medication Administration Training verification/certificate</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2019
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V 118	<p>Continued From page 2</p> <p>regardless of when the medications were administered; -She was not aware that there was a requirement that MARs were to be documented immediately after administration of medications.</p> <p>Interview on 10/17/19 with the Qualified Professional revealed: -He was aware that MARs were to be documented immediately after administration of medications; -The Provider had attended Medication Administration training and was informed to immediately document MARs after administration of medications.</p> <p>Due to the failure to accurately document medication administration it could not be determined if the client received his medications as ordered by the physician.</p>	V 118		



PRAISING HANDS, LLC.
5501 Executive Center Dr.
Suite 223
Charlotte, NC 28212
Office: 980.207.4317 Fax: 980-207-1287

December 10, 2019

Mental Health Licensure and Certification Section

2718 Mail Service Center

Raleigh, NC 27699-2718

RE: The Threat Home MH#049-144

Termination of Ownership

To Whom it may concern:

Please accept this letter as request to surrender ownership of the licensed facility referenced as The Threat Home. Please note that Praising Hands is aware of the "OPEN" status of a previous request of ownership by Life Alliance. It has been brought to our attention that the facility is currently serving a consumer in the home through Life Alliance and Partners Behavioral Health(MCO) in a contractual/accredited/client specific arrangement. Due to Praising Hands not being a contractual provider of Partners MCO nor Life Alliance we feel it is a conflict to remain the owners of the license for the Threat home. The issue of concern for this agency is responsibility without a role or relationship that could assure accountability. Please feel free to contact me at (980) 207-4317 if you have any questions about this request. Thank you for your attention to this matter.

Thank you

Sandra Lloyd CEO

Sandra Lloyd

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 01, 2019, this license is issued to

Praising Hands, LLC

to operate a mental health facility known as

The Threatt's Home

located at 111 Babbling Brook Road

Mooresville, North Carolina County: Iredell

This license is issued subject to the statutes of the
State of North Carolina, is not transferable and shall expire
midnight December 31, 2019.

Facility ID: 170406

License Number: **MHL-049-144**

Capacity: 2


Services:

27G.5600F Supervised Living/Alternative Family Living

Authorized by:



Secretary, N.C. Department of Health and
Human Services



Director, Division of Health Service Regulation

N.C. Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section
1800 Umstead Drive ■ 2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

CHANGE LICENSE APPLICATION FOR MH/DD/SAS FACILITIES

TYPE OF CHANGE:

- Facility Name
Change of Licensee/ Owner**
Ambulatory Bed(s) to Non Ambulatory Bed(s)
Adding a Mental Health Service to a Mental Health Hospital
Location* Within the Same County Into a Different County
Other; Please Specify:

FACILITY MHL#:

Capacity* Service Category

MHH#:

Note: *Change of Location & Change of Capacity require a Construction Fee. You will be invoiced for these fees. Do not send money for Construction Section when submitting this application.

**Change in Ownership requires a license fee to accompany this application

CURRENT LICENSE INFORMATION (complete requested change(s) on following pages)

1. CURRENT FACILITY NAME: THE THREAT HOME
2. CURRENT FACILITY SITE ADDRESS: (NO P.O. BOXES)
Street Address: 111 Babbling Brook Road
City: Mooresville State: NC Zip Code: 28112
Phone: 708 204317- Email:

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:
Name of Owner: Praising Hands LLC
Street Address: Executive Center Dr
City: Charlotte State: NC Zip Code: 28212
Phone: 980 207 4317 Email: sandralboss@hotmail.com

4. SIGNATURE OF CURRENT LICENSEE: The undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.
Name: Praising Hands LLC Title: General President
Signature: [Signature] Date: May 6, 2019

5. SIGNATURE OF REQUESTED NEW LICENSEE (if applicable): The undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.
Name: Allen Byrd Title: Owner
Signature: [Signature] Date: 5/1/19

ALL APPLICATIONS MUST BE MAILED TO ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

OFFICIAL USE ONLY: DHSR Form 5002

Licensure Categories:
Licensure Recommendation: DHSR Consultant:
Remarks:

Subject **The Threatt's Home MHL-049-144- Change of Ownership Application notice**
From Reeves, Danalouise V <Danalouise.Reeves@dhhs.nc.gov>
To slloyd@praisinghandsllc.com <slloyd@praisinghandsllc.com>, allen.byrd@lifealliancecellc.com <allen.byrd@lifealliancecellc.com>
Date 2019-05-09 12:10
Priority Highest

The Mental Health Licensure & Certification Section has received a change of ownership application for the following facility:

The Threatt's Home MHL-049-144

This email is to inform/remind both parties of the following:

- The current licensee is responsible for all licensure activity until the change of ownership is completed and the new ownership has their new license.
- If the change of ownership is denied, the current licensee remains responsible for the facility.

Upon completion of the application review process, each party will receive an email indicating the change of ownership was approved or denied.

Danalouise Reeves

Administrative Specialist I

Division of Health Service Regulation, Mental Health Licensure and Certification Section

North Carolina Department of Health and Human Services

Office: 919-855-3831

Fax: 919-715-8078

Danalouise.Reeves@dhhs.nc.gov

1800 Umstead Drive, Williams Building

2718 Mail Service Center

Raleigh, NC 27699-2718

-  Compose
-  Mail
-  Contacts
-  RSS
-  Calendar
-  Settings
-  Help
-  Logout

The Threatt's Home MHL-049-144- Change of Ownership Application notice

From [Reeves, Danalouise V](#) on 2019-05-09 12:10
Details Plain text

The Mental Health Licensure & Certification Section has received a change of ownership application for the following facility:

The Threatt's Home MHL-049-144

This email is to inform/remind both parties of the following:

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Upon completion of the application review process, each party will receive an email indicating the change of ownership was approved or denied.

Danalouise Reeves

Administrative Specialist I
Division of Health Service Regulation, Mental Health Licensure and Certification Section
North Carolina Department of Health and Human Services

Office: 919-855-3831
Fax: 919-715-8078
Danalouise.Reeves@dhhs.nc.gov

1800 Umstead Drive, Williams Building
2718 Mail Service Center
Raleigh, NC 27699-2718

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PRAISING HANDS, LLC.

Discharge Summary

(To be completed within 30 days of termination of services)

Name: [REDACTED] Record #: [REDACTED]

Date of Admission: 10/16/11 Date of Discharge: 1/17/19

Guardian: Sheps EL Care Coordinator: Stephanie Robinson

Presenting Condition (According to the "Presenting Condition" section of the Psychosocial Assessment that was completed upon admission)

Needs Residential Supports (AFL) services due having a diagnosis of Biopolar disorder, Psychosis, Depressive D/O Moderate Mental Retardation, being legally blind, having a seizure disorder and having social problems.

Extent to which goals and objectives were met (According to the individual plans and progress reviews that were completed during programming)

[REDACTED] received residential supports (AFL) services. Within the context of services; he received, community awareness and social goals in order to increase his independence. [REDACTED] has not met goal criteria and will need to continue to work on self-help goals to maintain his stability as well as to obtain more control over his well being.

Progress toward recovery or well-being (This is based on a review of functioning at admission, the participant's identified needs and goals, the level of goal achievement, and the level of functioning at discharge as compared to the level of functioning at admission)

Minimal progress has been made and criteria was not met.

Gains achieved during program participation (How did the participant's life improve during program participation)

[REDACTED] received Residential supports Services through Praising Hands, LLC. [REDACTED] did not experience any significant changes during his participation with the program. [REDACTED] guardian will be changing agencies form Praising Hands, LLC to Unique Caring effective 1/17/19.

Strengths, Needs, Abilities, Preferences (Review this section of the Psychosocial Assessment and compare to the participants functioning at discharge. What changes have occurred in these areas as a result of program participation?)

There were no changes that occurred as a result of program participation.

Services Provided (These should be listed according to the services listed in your program plans, program guides, marketing materials, etc.)

Check all that apply:

- Residential Support-AFL
- Community Living & Supports
- Respite
- Community Networking
- Supported Employment
- B3 Services:

Reason for Discharge: Request to change provider from Praising Hands, LLC to Carewell Agency in Charlotte

<input type="checkbox"/> Successfully completed program
<input type="checkbox"/> Referred/Transferred to more intense level of care
<input type="checkbox"/> Referred/Transferred to a less intense level of care
<input checked="" type="checkbox"/> Left voluntarily by choice
<input type="checkbox"/> Lack of progress, program initiated
<input type="checkbox"/> Lack of progress, participant initiated
<input type="checkbox"/> Program rule violation
<input type="checkbox"/> Medical Problem, unable to participate
<input type="checkbox"/> Legal Problem/Situation, unable to participate
<input type="checkbox"/> Change in geographic/living location
<input type="checkbox"/> Other:

Status of the Person at Discharge:

<input type="checkbox"/> Presenting Condition greatly improved
<input checked="" type="checkbox"/> Presenting Condition moderately improved
<input type="checkbox"/> Presenting Condition slightly improved
<input type="checkbox"/> Presenting Condition not improved
<input type="checkbox"/> Presenting Condition has worsened
<input type="checkbox"/> Other:

Recommended Support Systems and Services that will support continued recovery or well-being:

Person/Agency	Location/Address	Phone Number	Contact Person	First (or next) Appointment
Unique Caring	7128 Albrmarle Road Charlotte, NC 28227	(704)535-0093		

Medications at discharge, if applicable: N/A

Type	Strength	Dosage
Clonazepam	1 mg	Daily
Keppra	0.5 mg	Daily
Nasonex	50 mcg	Daily
Quetiapine	300 mg	Daily
Phenytoin	100 mg	Daily
Spirolactone	15 mg	PRN
Loratadine	10 mg	PRN

Discharge Summary Completed by:

Nadia H. Y. [Signature]

QP Signature

11/17/19

Date



Notice of Authorized Services

12/10/2019 12:46:00 PM

Praising Hands, LLC
5501 Executive Center Dr. Ste 223

Provider ID: [REDACTED]

TREATMENT AUTHORIZATION NUMBER: [REDACTED]

TAR REFERENCE NUMBER: [REDACTED]

Processed Date: 5/18/2018 10:49:16 AM

Insurance: Medicaid C Waiver

Consumer ID: [REDACTED]

Consumer Name: [REDACTED]

Consumer Address: [REDACTED]

Consumer Phone #: [REDACTED]

Consumer DOB: [REDACTED]

Consumer SS #: [REDACTED]

The following services are included in this treatment authorization

Service Definition: INNOVATIONS WAIVER - RESIDENTIAL SUPPORTS AFL

Service Codes	Total Units Approved
H2016 HI U2 Residential Supports Level 4 AFL	231

Authorization Effective Date

06/01/2018

Daily Max	Weekly Max	Monthly Max
1	7	31

Authorization End Date

* 01/17/2019 - client discharge date.

Weekly Maximums will be applied for all services from Sunday to Saturday.
Monthly Maximums will be applied for all services from the 1st day of the month to the last.

Notwithstanding this authorization, failure to comply with the terms and conditions of your contract with our organization or its policies and procedures will result in claims denial.

This instrument has been pre-audited in the manner required by the Local Government Budget and Financial Control Act, General Statute 159.

Should you have any questions please feel free to contact us at 1-800-939-5911.

This Is To Certify That

Kenneth Threatt
Has successfully completed
A training course for

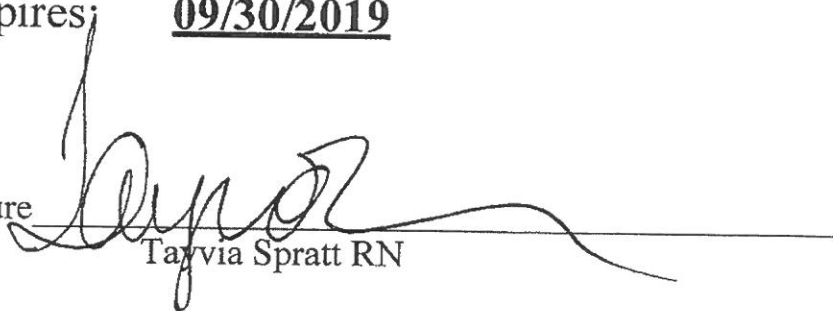
Medication Administration

Praising Hands LLC.
5501 Executive Center Drive Suite 223
Charlotte NC 28212

Presented: 09/10/2018

Expires: 09/30/2019

Instructor's Signature



Taryvia Spratt RN

This Is To Certify That

Tisha Threatt
Has successfully completed
A training course for

Medication Administration

Praising Hands LLC.
5501 Executive Center Drive Suite 223
Charlotte NC 28212

Presented: 09/10/2018

Expires: 09/30/2019

Instructor's Signature



Tayvja Spratt RN