



HOPE HAVEN

3815 N. Tryon St.  
Charlotte, NC 28206  
(704) 372-8809  
(704) 376-0113 fax

[www.hopehaveninc.org](http://www.hopehaveninc.org)

Joanna Eller, LCAS  
VP Clinical Services

**Board of Directors**

Chris Rich, Chair  
Rashida Gittens, Vice Chair  
Jon Carroll, Immediate Past Chair  
Joseph Donlevy, Secretary  
Denise Sawyer, Treasurer  
Ryan Apt  
Scott Dam  
Brian Gainey  
Kenston Griffin  
Ross Howard  
Juanita Kylander  
C. Renee Little  
Peggy McDonnell, Emeritus  
Michelle Moore  
Paresh Mutha  
Jodi Ramirez  
Judy Ranson, Emeritus  
Barbara Sheppard  
Cap. Michael Smith  
Darryl Strawberry  
Pete Thedinga  
James C. Thompson, Emeritus  
Suzanne Thompson  
Kenneth "Chip" Wildman  
Winye Wilks  
Richard "Stick" Williams, Emeritus

Jeannie Roberts, Nurse Practitioner  
Medical Advisor

February 24, 2020

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

Re: Hope Haven, Inc. Plan of Correction  
MHL # 060-381

Dear Gina McLain,

We received the results of the complaint and follow-up survey from January 31, 2020. I have enclosed the original of Hope Haven, Inc.'s signed Plan of Correction, which addresses each deficiency identified in the Revisit Report.

We welcome a follow up visit from you or another member of the North Carolina Department of Health and Human Services. If you have questions or desire additional information, please do not hesitate to contact me.

Thank you in advance for your consideration. We value our partnership with the Department of Health and Human Services and look forward to continuing that relationship in the future.

Sincerely yours,

Joanna Eller, LCAS  
VP Clinical Services

Enclosure

DHSR - Mental Health

FEB 28 2020

Lic. & Cert. Section

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL060-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ <b>MSR - Mental Health</b> <b>FEB 28 2020</b> B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2020</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>VILLAGES OF HOPE HAVEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 NORTH TRYON STREET CHARLOTTE, NC 28206</b> <b>Lic. &amp; Cert. Section</b>
---	--

(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 1/31/20. The complaints were substantiated (Intakes #159097, #159095). A deficiency was cited.</p> <p>This facility is licensed for the following service categories: This facility is licensed for the following service categories: 10A NCAC 27 G .4300 Therapeutic Community, 10A NCAC 27G .4100 Residential Recovery Programs for Individuals With Substance Abuse Disorders and Their Children.</p>	V 000	<p>Medication Requirements General POC:</p> <ol style="list-style-type: none"> <li>Hope Haven will consolidate the current 3 medications rooms into 1 centrally located medication room. This room will be staffed with experienced clinical staff that has completed the Hope Haven Medication Administration Training. The VP of Clinical Services will be responsible for this being completed by May 1, 2020.</li> <li>Hope Haven has implemented a new procedure for obtaining prescription refills for current resident's medications. (attached) This procedure includes steps to follow if the resident fails to get the prescription prior to the medication supply running out. The VP of Clinical Services is responsible for the training and implementation of this procedure on 02/25/2020 and monitoring the adherence of this procedure going forward.</li> </ol>	
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <ol style="list-style-type: none"> <li>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.</li> <li>Medications shall be self-administered by clients only when authorized in writing by the client's physician.</li> <li>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.</li> <li>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:                     <ol style="list-style-type: none"> <li>client's name;</li> <li>name, strength, and quantity of the drug;</li> <li>instructions for administering the drug;</li> <li>date and time the drug is administered; and</li> </ol> </li> </ol>	V 118	<ol style="list-style-type: none"> <li>Hope Haven has implemented a new procedure to ensure all resident's prescriptions have a corresponding Prescriber Letter and all medication changes have a Discontinuation Order. (attached) This procedure includes steps to take if the resident does not obtain these documents. The VP of Clinical Services is responsible for the training and implementation of this procedure on 02/25/2020 and monitoring the adherence of this procedure going forward.</li> <li>Hope Haven will audit Medication Records monthly using a 4 different audit methods:                     <ol style="list-style-type: none"> <li>The Medication Management Committee meets once a month and will audit 2 Medication Records from each program.</li> <li>NP/Counselor review: monthly the NP and Counselor will use the "Buddy System" to review all Medication Records of residents on that counselors case load. This will be a team effort where one person will review the medication while the other confirms the orders for any changes. This will include ensuring all medications are present in the residents medication box.</li> <li>Wingate Pharmacy Students: monthly students from Wingate Community Service Learning Program will audit Medication Records for 10% of the daily census. The VP of Clinical Services will be responsible for maintain the audit reports and to ensure all corrections have been made.</li> </ol> </li> </ol>	

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

*James Keller* **CAS**

TITLE

*VP Clinical Services*

(X6) DATE

*2-24-2020*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL060-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>VILLAGES OF HOPE HAVEN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 NORTH TRYON STREET CHARLOTTE, NC 28206</b>		
(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 118	<p>Continued From page 1</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on records review, interviews and observations, the facility failed to ensure medications were administered as ordered by a physician and MARS were kept accurate and current affecting 2 of 3 clients (#1,#3). The findings are:</p> <p>Finding #1: Review on 1/27/20 of client #1's record revealed: -admission date of 10/1/19; -diagnoses of Methamphetamine Use Disorder-Moderate, Post Traumatic Stress Disorder and Nicotine Use Disorder.</p> <p>Further review on 1/31/20 of client #1's record revealed the following physicians' orders for prescribed medications: -Hydroxyzine 50mg one tablet four times daily dated 12/18/19 with a discontinue order dated 1/27/20; -Halobetasol 0.05% apply twice daily as needed dated 12/18/19; -Prenatal Vitamins with Iron one tablet daily dated 12/18/19; -Nicotine Patch 7gm patch one daily dated 12/18/19; -sertaline(generic for Zoloft) 100mg one tablet daily dated 12/18/19;</p>	V 118		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL060-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VILLAGES OF HOPE HAVEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 NORTH TRYON STREET CHARLOTTE, NC 28206</b>
---	---

(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 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>-Amoxicillin 875mg one tablet twice daily for 10 days dated 1/18/20;</li> <li>-Ibuprofen 800mg one tablet three times daily as needed dated 1/18/20;</li> <li>-Acetaminophen 500mg one tablet every 4-6 hours needed dated 1/18/20.</li> </ul> <p>Observation on 1/31/20 at 11:50am of client #1's medications on site revealed:</p> <ul style="list-style-type: none"> <li>-Prenatal Vitamins with Iron one tablet daily dispensed 1/8/20;</li> <li>-Nicotine Patch 7gm patch one daily dispensed 12/6/19;</li> <li>-sertaline 100mg one table daily dispensed 1/8/20;</li> <li>-Amoxicillin 875mg one tablet twice daily for 10 days dispensed 1/19/20;</li> <li>-Ibuprofen 800mg one tablet three times daily as needed dispensed 1/19/20;</li> <li>-Acetaminophen 500mg one tablet every 4-6 hours needed over the counter with expiration date of 9/2021 and not opened yet.</li> </ul> <p>Continued observation on 1/31/20 at 11:50am of client #1's medications revealed the following medications not on site:</p> <ul style="list-style-type: none"> <li>-Hydroxyzine 50mg one tablet twice daily;</li> <li>-Halobetasol 0.05% apply twice daily as needed;</li> <li>-Methylprednisone 4mg one tablet for 7 days;</li> <li>-sertaline 50mg one tablet in the pm.</li> </ul> <p>Review on 1/31/20 of client #1's MARs from 11/1/19-1/31/20 revealed the following:</p> <ul style="list-style-type: none"> <li>-Hydroxyzine 50mg one tablet twice daily documented as administered 12/6-12/30, blank for 12/31(am), 1/16-1/27 blank;</li> <li>-sertraline 50mg one tablet in the pm documented as administered 11/1-11/2, 11/7-11/30, 12/1-12/31, not listed on 1/2020 MAR;</li> <li>-Halobetasol 0.05% apply twice daily as needed</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL060-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VILLAGES OF HOPE HAVEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 NORTH TRYON STREET CHARLOTTE, NC 28206</b>
---	---

(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 118	<p>Continued From page 3</p> <p>documented discontinued on 1/2020 MAR; -Methylprednisone 4mg one tablet daily for 7 days documented as administered from 12/1-12/17 with "completed" written on 12/2019 MAR.</p> <p>Additional review on 1/31/20 of client #1's record revealed no physicians' orders for the following medications; -Hydroxyzine 50mg decreased to one tablet twice daily no initial physician's order and no discontinue physician's order; -sertaline 50mg one tablet in the pm no initial physician's order and no discontinue physician's order; -Halobetasol 0.05% apply twice daily as needed with no discontinue order; -Methylprednisone 4mg one tablet for 7 days no initial physician's order.</p> <p>Interview on 1/31/20 with client #1 revealed: -got her medications as prescribed on a daily basis; -medication calls were at 7am, 1pm and 6pm.</p> <p>Finding #2: Review on 1/27/20 of client #3's record revealed: -admission date of 12/3/19; -diagnoses of Opioid Use Disorder-Severe, Methamphetamines Use Disorder-Severe, Cannabis Use Disorder-Mild, Xanax Use Disorder-Severe, Hepatitis C and Anxiety Disorder.</p> <p>Review on 1/31/20 of client #3's MARs from 12/3/19-1/31/20 revealed: -Cough DM 30mg/05ml 10ml every 12 hours as needed listed on 1/2020 MAR; -documented as administered on 1/7/20 at 9pm, 1/8/20-1/11/20 twice daily at 6am and 6pm.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL060-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VILLAGES OF HOPE HAVEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 NORTH TRYON STREET CHARLOTTE, NC 28206</b>
---	---

(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 118	<p>Continued From page 4</p> <p>Observation on 1/31/20 at 11:17am of client #3's medications on site revealed Cough DM 30mg/05ml 10ml every 12 hours as needed not on site.</p> <p>Further review on 1/31/20 of client #3's record revealed no initial physician's order nor a physician's discontinue order present in the record for Cough DM 30mg/05ml 10ml every 12 hours as needed.</p> <p>Interview on 1/31/20 with the Clinical Director revealed: -had a counselor leave suddenly and trying to find needed documentation; -trying to find the needed physicians' orders for clients but unable to find some; -plan to consolidate three medication rooms to one medication room and assign main staff to handle all medications; -too many staff handling the medications.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 118		

## Hope Haven Medication Refill Procedure

Medications need to be refilled prior to the residents supply of medications is completely out. Refill medication slips have been placed in the medication rooms. These slips need to be filled out by the resident and taken with them to make the refill process easier.

Step 1- The Resident will fill out the slip with the following information:

- RX Name
- RX refill number
- Number and Name of the Pharmacy
- Number and Name of the Prescribing Physician

Step 2- The Resident will take the slip with them and contact the pharmacy for the refill.

*When: The resident has **5 days** (not doses) remaining of the prescription. The pharmacy may not refill the prescription at that time, but the resident needs to be aware and start making preparation to obtain the medication.*

*The Resident is still responsible for getting the prescription refilled from the pharmacy. The purpose of the slip is so the resident can have the information readily available when calling for the refill.*

Any prescription that is not refilled before the supply is depleted will require the resident to:

- A. See the prescribing physician for a discontinued order
- Or
- B. See the NP at Hope Have to get a discontinued order

A or B will be required within 24 hours of the last dose of medication.

*Once a medication has been discontinued it will be the responsibility of the resident to obtain another prescription and the corresponding prescriber letter.*

## **Hope Haven Medication Management Procedure**

All residents' medications are required to have a corresponding Prescriber Letter and/or Discontinued Order.

### Resident Responsibility:

When a new resident admits to Hope Haven with a medication the resident must arrive with a Prescriber Letter for those medications. The resident is responsible for obtaining this letter.

When an existing resident obtains a new prescription they must obtain a Prescriber Letter for those Medications. The resident is responsible for obtaining this letter

### Staff Responsibility:

When a Prescriber Letter is not obtained by the resident within 24 hours the Clinical Staff will send notice to the Intake Assistant that the letter needs to be obtained. The Intake Assistant will fax/call the prescribing physician to get the letter. The Intake Assistant will make 2 attempts to contact the prescriber. A fax confirmation will be retained for documentation of each attempt.

If a letter cannot be obtained within a 48 hour period the Intake Assistant will notify the Hope Haven NP for medication review appointment. The Hope Haven NP will write a new Prescription or a Discontinued Order.

### Discontinued Medications:

When a resident wishes to discontinue a medication it is the responsibility of the resident to obtain a Discontinued Order for that medication. Any refusal to take a prescribed medication will be documented properly and an appointment with the Hope Haven NP will be scheduled within 48 hours to obtain a Discontinued Order.

*Once a medication has been discontinued it will be the responsibility of the resident to obtain another prescription and the corresponding prescriber letter.*