STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-804	A. BUILDING: _____ B. WING _____	C 01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON'S HOUSE OF HOPE FAMILY CARE H	2117 STAR SAPPHIRE DRIVE RALEIGH, NC 27610

(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 A complaint survey was completed January 8, 2021. The complaint was substatiated (intake # NC00172671). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living	V 000		
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 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	V 367		

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V 367	Continued From page 1 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 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;	V 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON'S HOUSE OF HOPE FAMILY CARE	2117 STAR SAPPHIRE DRIVE RALEIGH, NC 27610

(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) COMPL DATE
V 367	Continued From page 2 (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 report all Level II incidents to the Local Management Entity/ Managed Care Organization (LME/MCO). The findings are: Review on 12/30/20 of the facility's records for Client #1 revealed: -Admitted: 2006 -Diagnosis: Autism, Mood Disorder Not Otherwise Specified (NOS), History of feeding disorder, Severe Intelluctual Developmental Disability Review on 1/06/21 of North Carolina Incident Response Improvement System (IRIS) revealed the following: -No incidents that involved client #1 During interview on 12/30/20 and 1/08/21 the Licensee reported: -There was an incident that happened on	V 367	The orginal incident report that was completed and thought to have been submitted was reported not to have been in the IRIS system. On 1/22/2021 Alliance Health Plan provided assistance to the licensee to ensure the submiission of the Incident Report into the IRIS system. A copy of that submission confirmation is attached. In the future, all reportable incidents will be timely submitted by the CEO/licensee. It is now clearly understood by the licensee that Alliance Health Plan provides support for the IRIS system and the licensee is now certain to have the resources necessary to complete and submitt any future incident reports.	

n of Health Service Regulation

NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON'S HOUSE OF HOPE FAMILY CARE	2117 STAR SAPPHIRE DRIVE RALEIGH, NC 27610

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
Continued From page 3 12/15/19 -Client #1 was taken to the hospital for injuries that occured -Staff did not witness -Doesn't know what happened -She did what she thought to submit IRIS report -Has called several people at Divison of Health Service Regulation (DHSR) to assist with completing the incident report -Has called LME/MCO to assist with IRIS, they referred her to DHSR -Need some assistance with the IRIS, doesn't understand the system	V 367		

NC DMH/DD/SAS

North Carolina Incident Response Improvement System

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Welcome to the NC Incident Response Improvement System

Incident Submission Completed

The submission of Incident Number:

1ab8d58a0d

was completed successfully.

Continue

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

1/19/21

Carol Johnson, CEO/QP
Johnson's House of Hope Family Care Home, LLC
2509 Rolling Pines Avenue
Durham, NC 27703

Re: Complaint Survey completed 1/8/21
Johnson's House of Hope Family Care Home, LLC, 2117 Star Sapphire Drive, Raleigh, NC 27610
MHL # 092-804
E-mail Address: johnson.l.e@msn.com
Intake #NC00172671

Dear Ms. Johnson:

Thank you for the cooperation and courtesy extended during the complaint survey completed 1/8/21. 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

- All other 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 3/9/21.

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.***

1-19-21
Carol Johnson
Johnson's House of hope Family Care Home, LLC

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 Renee Kowalski at 919-552-6847.

Sincerely,

Keisha N. Douglas

Keisha N. Douglas
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant