STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		MHL078-150	B. WING			-C 1 <b>2/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
HOPE H	OUSE		LOWERY R N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	on March 12, 2021. substantiated (intak Deficiencies were c This facility is licens 10A NCAC 27G .17	te #NC00174445).				
V 114	10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster points and exacuation proposted in the facility (c) Fire and disaster shall be held at least repeated for each sunder conditions that	ncy Plans and Supplies 707 EMERGENCY PLANS In for each facility and plan shall be developed and by the appropriate local  e made available to all staff cedures and routes shall be of the developed and shall be of the developed and shall be conducted at simulate fire emergencies.  It was a supplies to the developed and shall be the developed at simulate fire emergencies.  It was a supplies to the developed and shall be the developed at simulate fire emergencies.	V 114			
	facility failed to ensume held quarterly and refindings are:  Review on 03/04/21 Plan Drill Log" reveals	view and interviews, the ure fire and disaster drills were epeated on each shift. The				

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

(X6) DATE TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	7. BOILDING		.c
		MHL078-150	B. WING	<u> </u>		2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HOPE H	OUSE		LOWERY R N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 114	(8am to 8pm) and N - No fire drills docur thru December 202 - No fire drills docur September 2020 (3 Weekend (8pm-8ar - No disaster drills of 2020 thru December Weekend (8am to 8 - No disaster drills of thru September 202 and Weekend (8pm) Interview on 03/09/2 - She started workin 2021 She had not partice Interview on 03/12/2 - She had submitted drills she could find - She was aware di completed on all the repeated quarterly She would try to lo	Veekend (8pm to 8am). mented from October 2020 0 (4th quarter) for all shifts. mented from July 2020 thru rd quarter) for 2nd shift and m). documented from October er 2020 (4th quarter) for 8pm and 8pm to 8am). documented from July 2020 20 (3rd quarter) for 1st, 3rd n to 8am). 21 staff #1 stated: ng at the facility in January sipated in a fire or disaster drill. 21 the Licensee stated: d all of the facility emergency saster drills had to be de designated shifts and ocate the missing drills. stitutes a re-cited deficiency	V 114			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs.		V 118			

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STATE FORM 6899 VV4711 If continuation sheet 2 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-	
		MHL078-150	D. WING		03/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HOPE HO	OUSE		LOWERY R N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	clients only when as client's physician.  (3) Medications, incadministered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug.  (5) Client requests checks shall be recorded.	uthorized in writing by the sluding injections, shall be by licensed persons, or by a trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The	V 118			
	failed to administer physician and failed	views and interview the facility medications as ordered by a I to keep MARs current ree audited clients (#1, #3 and				
	Finding #1: Review on 03/04/21 record revealed:	I and 03/08/21 of client #1's				

Division of Health Service Regulation

- 13 year old male.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		В	C
		MHL078-150	B. WING		R- <b>03/1</b>	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOPE H	OUSE		) LOWERY R N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 3	V 118			
	- Admission date of					
	orders revealed: 10/16/20 - Risperidone (anti-	1 of client #1's physician psychotic) 1 milligram (mg) - orning and one tablet at				
	150mg and 300mg	e (treats Bipolar Disorder) - take twice daily. tiety) 25mg - take one daily.				
	Review on 03/08/21 of client #1's February 2021 and March 2021 MARs revealed the following blanks:  March 2021 - Lithium 03/02/21 at 7am.					
	and 02/24/2 at 7am	21 and 02/25/21 at 7pm.				
	record revealed; - 15 year old male Admission date of - Diagnoses of Pos Attention Deficit Hy and Zoophilia.	t Traumatic Stress Disorder, peractivity Disorder (ADHD)				
	physician orders re 02/1/21	1 and 03/08/21 of client #3's vealed:				

Division of Health Service Regulation

STATE FORM 6899 VV4711 If continuation sheet 4 of 16

	IT OF DEFICIENCIES	l'	(VO) MULTIPL	E CONCERNICATION	(VO) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDING:	<del></del>		
			B 14/11/0		R-	
		MHL078-150	B. WING		03/1	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3775 OLI	LOWERY R	OAD		
HOPE H	OUSE		N, NC 28386			
(V4) ID	QLIMMADV QTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
V 118	Continued From pa	ge 4	V 118			
	- Δtaray 25mg - tak	e 2 tablets at bedtime.				
		rgies) 10mg - take once daily.				
	02/24/21					
		ts ADHD) 60mg - take one				
	tablet every morning					
	Review on 03/04/21	1 and 03/08/21 of client #3's				
		March 2021 MARs revealed				
	the following:					
	March 2021					
	- Zyrtec transcribed	as take as needed. The				
	physician ordered s					
	- No staff initials to	•				
	administered on 03					
		indicate the Atomoxetine was				
	administered on 03	/03/21 and 03/04/21.				
	February 2021					
		indicate Atarax was				
		/16/21 and 02/25/21.				
	- No staff initials to					
	administered on 02	/01/21.				
		indicate Atomoxetine was				
	administered on 02	/24/21.				
	Finding #2:					
	Finding #3:	1 and 03/08/21 of client #4's				
	record revealed:	1 and 03/06/21 of client #4 \$				
	- 16 yea old male.					
	- Admission date of	<sup>5</sup> 09/18/20.				
		ID, Autism Spectrum Disorder				
	and Adjustment Dis					
	D i	A of allow A HAIs at the				
		of client #4's physician				
	orders dated 02/24/					
	- Zolott (anti-depres	ssant) 100mg - take at				
		s seizures) 100mg - take 3				
	times daily.	s scizules, rouning - lake s				

Division of Health Service Regulation

STATE FORM 6899 VV4711 If continuation sheet 5 of 16

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R-	
		MHL078-150	B. WING		03/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HOPE H	DUSE		LOWERY R N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 5	V 118			
	- Adderal (treats ADHD) 20mg - take twice daily Trazodone (anti-depressant) 150mg - take at bedtime.					
	Review on 03/08/21 of client #4's February 2021 MAR revealed the following blanks: - Zoloft - 02/25/21 Gabapentin - 12pm - 02/19/21, 02/25/21, 02/27/21 and 02/28/21 and 7pm - 02/19/21 and 02/25/21 Adderall - 12pm 02/19/21, 02/25/21 and 02/28/21 Trazodone - 02/25/21.					
	Interview on 03/12/21 the Licensee stated: - She had addressed medication issues with the staff recently Staff are to ask clients to get medications one at a time Staff should then complete documentation No clients had missed medications Staff may forget to initial MARs.  Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.					
	This deficiency con and must be correct	stitutes a re-cited deficiency ted within 30 days.				
V 296	27G .1704 Residen Staffing	tial Tx. Child/Adol - Min.	V 296			
	telephone or page.	04 MINIMUM STAFFING essional shall be available by A direct care staff shall be cility within 30 minutes at all				

Division of Health Service Regulation

STATE FORM 6899 VV4711 If continuation sheet 6 of 16

A. BUILDING: R-C  MHL078-150  B. WING 03/12/202	
	021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HOPE HOUSE 3775 OLD LOWERY ROAD	ļ
SHANNON, NC 28386	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	(X5) OMPLETE DATE
times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for fore, six, seven or eight children or adolescents; (2) three direct care staff shall be present for nine, ten, eleven or twelve children or adolescents; (a) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (b) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescent's individual strengths and needs as specified in the treatment plan.	

Division of Health Service Regulation

STATE FORM 6899 VV4711 If continuation sheet 7 of 16

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				<del></del>	R-	
		MHL078-150	<u>.</u>		03/1	2/2021
	PROVIDER OR SUPPLIER		DRESS, CITY, S LOWERY R	STATE, ZIP CODE		
HOPE H	DUSE		N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 296	Continued From page 7		V 296			
	facility failed to have direct care staff who were present and a	views and interviews, the e the minimum number of en children or adolescents wake. The findings are:  I and 03/08/21 of client #1's				
		ptive Mood Dysregulation				
	record revealed; - 15 year old male Admission date of - Diagnoses of Pos	and 03/08/21 of client #3's 10/09/20. t Traumatic Stress Disorder, peractivity Disorder (ADHD)				
	record revealed: - 16 yea old male Admission date of	ID, Autism Spectrum Disorder				
	<ul> <li>Staff are at the factoring</li> <li>One staff worked sleepy.</li> </ul>	the facility over four months.				
		21 and 03/12/21 the Licensee				

Division of Health Service Regulation

STATE FORM 6899 VV4711 If continuation sheet 8 of 16

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL078-150	B. WING		R-C <b>03/12/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	03/1	2/2021
			LOWERY R			
HOPE HO	JU3E	SHANNON	N, NC 28386	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
V 296	client awake hours Staff #3 worked a	asleep at times on shift during	V 296			
V 364	V 364 G.S. 122C- 62 Additional Rights in 24 Hour Facilities  § 122C-62. Additional Rights in 24-Hour Facilities.  (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to:  (1) Send and receive sealed mail and have		V 364			
	assistance when ne (2) Contact and co and at no cost to the physicians, and prividevelopmental disa professionals of his (3) Contact and co there is a client adv	nsult with, at his own expense e facility, legal counsel, private rate mental health, bilities, or substance abuse choice; and nsult with a client advocate if ocate.				
	restricted by the face exercise these right (b) Except as proving of this section, each treatment or habilitatimes keeps the right (1) Make and receivable. All long distant the client at the time collect to the receivable. (2) Receive visitors	ve confidential telephone ace calls shall be paid for by e of making the call or made				

Division of Health Service Regulation

STATE FORM 6899 VV4711 If continuation sheet 9 of 16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	<del></del>	COIVIE	LETED
		MHL078-150	B. WING		R- <b>03/1</b>	.C <b>2/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HODE H	OUCE	3775 OLD	LOWERY R	OAD		
HOPE HO	JUSE	SHANNON	N, NC 28386	<b>;</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	p.m.; however visiti over therapies; (3) Communicate a supervision with incupon the consent of (4) Make visits out unless: a. Commitment put the result of the clie violent crime, include assault with a dead respondent was four insanity or incapable.	roceedings were initiated as ent's being charged with a ding a crime involving an ally weapon, and the und not guilty by reason of e of proceeding;				
	b. The client was committed to the far commitment to a commitment of Adult Committee Conditions of Committee Conditions prescribes (5) Be out of doors facilities and equipalities and equipalities and equipalities and equipalities and equipalities and equipalities and client is being held proceed pursuant to (7) Participate in reasonal clothing and (8) Keep and spendown money; (9) Retain a driver prohibited by Chaptand	voluntarily admitted or acility while under order of correctional facility of the correction of the Department of the De				

DIVISION	of Health Service Re	eguiation			_	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MIII 070 450	B. WING		R-C <b>03/12/2021</b>	
		MHL078-150	D. WING	· · · · · · · · · · · · · · · · · · ·	03/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE		
·· ·			LOWERY R			
HOPE HO	DUSE					
		SHANNUI	N, NC 28386			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	KLGOLATOKT OK L	SCIDENTII TING INI ORIVIATION)	TAG	DEFICIENCY)	INAIL	D/ (TE
				,		
V 364	Continued From pa	ge 10	V 364			
	/->   -  #: 4- 4 -					
		ne rights enumerated in G.S.				
ı		.S. 122C-57 and G.S.				
		.S. 122C-61, each minor client				
		atment or habilitation in a				
		the right to have access to				
		rision and guidance. In				
	recognition of the m	ninor's status as a developing				
	individual, the mino	r shall be provided				
	opportunities to ena	able him to mature physically,				
	emotionally, intelled	ctually, socially, and				
		v of the physical, emotional,				
		naturity of the minor, the				
		Il provide appropriate				
		on and control consistent with				
		he minor pursuant to this Part.				
		so, where practical, make				
	-	to ensure that each minor				
		ment apart and separate from				
		the treatment needs of the				
	minor client dictate					
		ho is receiving treatment or				
		24-hour facility has the right to:				
		and consult with his parents or				
	-	ency or individual having legal				
	custody of him;					
		nsult with, at his own expense				
		responsible person and at no				
		egal counsel, private				
		mental health, developmental				
	disabilities, or subs	tance abuse professionals, of				
	his or his legally res	sponsible person's choice; and				
		nsult with a client advocate, if				
	there is a client adv					
		I in this subsection may not be				
		cility and each minor client				
	•	rights at all reasonable times.				
		ided in subsections (e) and (h)				
		n minor client who is receiving				
		ation in a 24-hour facility has				
	u caunciil di Habiilla	auon in a 24-nour facility has				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			A. DUILDING.	<del></del>	_	
		MUU 070 450	B. WING		R-C <b>03/12/2021</b>	
		MHL078-150	ט. איוואט		03/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HOPE HO	OLICE.	3775 OLD	<b>LOWERY R</b>	OAD		
HOPE H	JU3E	SHANNO	N, NC 28386	<b>3</b>		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
V 364	Continued From no	go 11	V 364			
V 304	Continued From pa	ge 11	V 304			
	the right to:					
		ive telephone calls. All long				
		be paid for by the client at the				
	· ·	call or made collect to the				
	receiving party;	9 11 4.				
		ve mail and have access to				
		ostage, and staff assistance				
	when necessary; (3) Under appropriate supervision, receive					
		hours of 8:00 a.m. and 9:00				
		at least six hours daily, two				
		I be after 6:00 p.m.; however				
		e precedence over school or				
	therapies;	·				
		l education and vocational				
		ice with federal and State law;				
		daily and participate in play,				
		sical exercise on a regular				
	basis in accordance					
		ibited by law, keep and use nd possessions under				
		sion, unless the client is being				
		apacity to proceed pursuant to				
	G.S. 15A-1002;	-p, p				
	(7) Participate in re	eligious worship;				
		individual storage space for				
		personal belongings;				
		and spend a reasonable sum				
	of his own money; a					
		s license, unless otherwise				
		er 20 of the General Statutes. erated in subsections (b) or (d)				
		be limited or restricted except				
		fessional responsible for the				
		lient's treatment or habilitation				
		ement shall be placed in the				
		ndicates the detailed reason				
		he restriction shall be				
		ated to the client's treatment or				

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Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED  R-C 03/12/2021		
MHL078		MHL078-150					
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
HODE H	OUEE		LOWERY R				
HOPE H	JUSE	SHANNON	N, NC 28386				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 364	Continued From page 12		V 364				
	Continued From page 12  habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.						
	facility restricted the clients (#1, #2 and	et as evidenced by: views and interviews, the e rights of 3 of 3 audited #3) by restricting their ability to elephone calls. The findings					
	Review on 03/04/22 record revealed: - 13 year old male Admission date of	1 and 03/08/21 of client #1's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL078-150	B. WING		R- <b>03/1</b>	C <b>2/2021</b>
<u> </u>				STATE, ZIP CODE		
			LOWERY R			
HOPE H	JUSE	SHANNOI	N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 364	Continued From page 13		V 364			
	<ul> <li>Diagnosis of Disruptive Mood Dysregulation Disorder.</li> <li>No documentation of restriction of calls.</li> </ul> Review on 03/04/21 and 03/08/21 of client #3's					
	record revealed; - 15 year old male Admission date of 10/09/20 Diagnoses of Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder (ADHD) and Zoophilia No documentation of restriction of calls.					
	Review on 03/04/21 and 03/08/21 of client #4's record revealed: - 16 yea old male Admission date of 09/18/20 Diagnoses of ADHD, Autism Spectrum Disorder and Adjustment Disorder No documentation of restriction of calls.					
	Interview on 03/04/2 - He was able to ma Friday and Sundays	ake calls on Wednesday,				
	Interview on 03/04/2 - He was able to ma Friday and Sundays	ake calls on Wednesday,				
	stated: - She had not place the consent page for - She would address rights committee ar - She would follow to calls was addresse	up to ensure the restriction of				

Division of Health Service Regulation

and must be corrected within 30 days.

STATE FORM 6899 VV4711 If continuation sheet 14 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		l R	-C	
MHL078-150		MHL078-150	B. WING		R-C <b>03/12/2021</b>		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
HOPE H	OUSE		LOWERY R N, NC 28386				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf- manner and shall b odor.	I its grounds shall be e, clean, attractive and orderly e kept free from offensive	V 736				
	was not maintained and orderly manner of and orderly manner of the wall of the facility in client and off the walls. An eleaway from the wall. Client #3's bedroof area of paint peeled walls had dark man client #1's bedsid The closet door had peeled away. Client #2's bedroof drawers. The close in he surface. The hallway bathr light fixture.	on and interview, the facility in a safe, clean, attractive The findings are:  04/21 at approximately ind slats were visible outside the state of paint popping extrical receptacle had pulled					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R-C		
		MHL078-150	B. WING			2/2021	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HOPE H	OUSE		) LOWERY R N, NC 28386				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 736	Continued From page 15		V 736				
	to their rooms.  - It was hard to complete repairs with clients in the rooms.						
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.						

6899