

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on January 4, 2022. The complaint was substantiated intake #NC00182844. Deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.</p> <p>A sister facility is identified in this report. The sister facility will be identified as sister facility A and the clients will be identified as client A1, client A2 and client A3.</p> <p>The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 512	<p>27D .0304 Client Rights - Harm, Abuse, Neglect</p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with</p>	V 512		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 1</p> <p>Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 1 of 1 licensee (Licensee) exploited 2 of 2 clients (#1). The findings are:</p> <p>Cross Reference: 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (Tag V542) Based on record reviews and interviews, the facility failed to do the following: (1) manage and maintain records of client personal funds as required and in accordance with the facility policy and procedures; (2) keep clients' personal funds separate from any operating funds; (3) provide quarterly accounting of clients' personal fund accounts, affecting 2 of 2 clients (#1 and #2).</p> <p>Observations of the facility on 12/15/21 and 12/17/21 revealed: -A room with 2 TVs each with a different game system attached to it, various controllers for the game systems, 2 gaming chairs and a single chair. -Client #1 had one TV in his bedroom, 1 pair of black/gold branded sneakers size 10, 1 pair of blue sneakers size 10.5, a pair of brown boots size 10, a pair of black boots sized 10.5, 1 pair of red/white branded sneakers, 1 pair gray loafers, 2 pair of slides, 2 pair brown sneakers, and 1 pair sandals in his closet. No orange/white/black branded sneakers observed. -Client #1's shoe sizes ranged from size 10 to 10.5.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 2</p> <p>Review on 12/15/21 of client #1's record revealed: -41 year old male admitted 8/1/02. -Diagnoses included Bipolar I Disorder, Unspecified; Intermittent Explosive Disorder; Intellectual Developmental Disability- Mild and Tobacco Use Disorder. -Client #1 had been in a vehicular accident on 12/25/19.</p> <p>Review between 12/15/21 - 1/4/22 of client #1's financial records revealed: -Social Security Administration (SSA) Supplemental Security Income (SSI) information letters dated 9/30/20 revealed a one time social security benefit payment of \$8,465.50; a monthly social security benefit payment of \$1029.10 to be paid beginning December 2019 through December 2020 and a SSA information letter dated 1/27/21 that revealed a revised social security benefit in the amount of \$1045.00 to be paid monthly beginning January 2021. -Client #1's consumer monthly funds report with client #1's signature and various staff initials for receiving \$76.00 per month from 9/1/17 through 12/4/21. -A personal injury claim letter dated 8/10/21 addressed to client #1 with a ledger from a local law firm detailing: -An insurance settlement for client #1 for \$24,000; Attorney fees of \$7,999.20; Case expenses \$220.76; -medical bill lien payment \$1,214.85 and a total disbursement payout to client #1 in the amount of \$14,565.28. -Client #1's settlement proceeds check stub from the law firm in the amount of \$14,565.28. -A transaction receipt dated 7/29/21 for a net deposit of \$12,565.28 (after \$2,000 given to</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 3</p> <p>client #1) into the joint residential fund checking account where personal funds for client #1, client #2 and 3 clients (client A1, client A2 and client A3) from sister facility A are deposited.</p> <p>-Physician receipt dated 7/19/21 in the amount of \$30.00.</p> <p>-An undated Ophthalmologist receipt in the amount of \$6.00</p> <p>-A dental receipt dated 7/29/21 in the amount of \$3.00</p> <p>-A receipt dated 10/2/20 from an online retailer with various clothing items and birthday party decorations in the amount of \$253.11.</p> <p>-A receipt dated 11/4/20 for \$100.00 for a restaurant gift card.</p> <p>-A receipt dated 6/25/20 in the amount of \$1411.21 for 2 game system consoles that cost \$299.99 each; a tv that cost \$329.99; 2 game controllers that cost \$59.99 and \$49.99; 3 games that were \$24.99, \$53.99 and \$59.99; and 3 protection plans that were \$39.99 and 2 were \$49.99.</p> <p>-Two receipts from a local retailer with the same date, with a one minute transaction time difference and with similar items as follows: Purchase time 7:59pm, Total \$33.91 for 2 shirts and 2 pairs of shorts; Purchase time 8:00pm, Total \$57.19 for 3 pairs of shorts, and 3 shirts.</p> <p>-A receipt from a local video game retailer dated 11/14/20 for a \$50.00 gift card.</p> <p>-A receipt from a local retailer dated 10/4/20 in the amount \$733.38 for a cell phone, a 2 year protection plan, screen protector and prepaid calling plan.</p> <p>-An undated furniture receipt in the amount of \$954.35 for a full sized bedroom suit and 1 full sized box spring.</p> <p>-A furniture receipt dated 10/8/20 in the amount of \$427.95 for an accent chair.</p> <p>-No other receipts provided for review.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 4</p> <p>Review between 12/15/21-1/4/22 of an expense list and receipts from 7/28/20-10/24/21 for client #1 revealed that his personal funds paid for the following:</p> <ul style="list-style-type: none"> -2 hotel stays from 8/14/21-8/15/21 in the amount of \$1159.12 for one room and \$1296.15 for another room for the monster truck bash in a nearby city 225 miles from the facility. -Mileage reimbursement to staff #2/Licensee's spouse for travel to both the nascar race on 10/9/21-10/10/21 for \$225.00 and the monster truck bash on 8/14/21-8/15/21 for \$225.00. -A receipt with two combo meals and a drink on 10/9/21 for \$36.14. -A receipt with two combo meals and 2 drinks during the nascar trip in October 2021 for \$41.69. -A receipt with two biscuits, 2 hash rounds and 2 drinks on 10/9/21 for \$10.78. -The expense list had shoe purchases on 8/28/21 and 8/29/21 for \$139.10 each and receipts revealed: <ul style="list-style-type: none"> -A receipt dated 8/28/21 at 7:55pm for an orange/black/white pair of sneakers size 10.5 for \$130.00, an orange/black/white pair of sneakers size 9.5 for \$130.00 and a backpack for \$65.00 and the receipt totaled \$347.75. -A receipt dated 8/28/21 at 7:57pm for an orange/black/white pair of sneakers size 9.5 for \$130.00 and the receipt totaled \$139.10. -A receipt with a pair of black/white/red sneakers purchased on 1/28/21 for \$144.45. -A hotel stay from 10/9/21-10/10/21 for the nascar race trip on 10/9/21-10/10/21 in a nearby city 225 miles from the facility for \$278.03. -A receipt for a birthday cake for \$516.81 on 12/6/21. -Two TV's for \$149.99 and \$249.99 and two protection plans for \$19.99 and \$29.99 purchased on 7/28/20. 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 5</p> <p>Review on 1/4/22 of receipts provided by client #1 for purchases from the \$2,000.00 the Licensee stated he received in cash on 7/29/21 after depositing his settlement check revealed:</p> <ul style="list-style-type: none"> -A receipt with an illegible date and descriptions for \$27.82. -A receipt dated 12/30/21 from local grocery store for cake mix and frosting for \$3.55 -A receipt dated 9/3/21 from a pastry shop for \$1.00. -A receipt dated 8/15/21 from a restaurant for \$5.34. -A receipt with an illegible date for a 30 gallon tote for \$14.98. -A receipt dated 8/15/21 for 2 bottles of water for \$2.55. -A receipt dated 8/14/21 a burger, fries and drink for \$4.28. -No additional receipts received to support the \$2,000 in cash Licensee stated client #1 received on 7/29/21 from his settlement check. <p>Review on 1/4/22 of a funds request for client #1 dated 12/23/21 revealed:</p> <ul style="list-style-type: none"> -"I [Client #1], request \$200.00 to be deducted from my funds. I am receiving these funds in cash on 12-23-21. I understand that I am responsible for keeping up with my own receipts for future financial reviews." -Signatures on the fund request were client #1's, Licensee and a board member. -No receipts were provided to account for the \$200.00 cash client #1 received on 12/23/21. -No other funds request documentation was provided for review. <p>Review on 1/4/22 of 2 bank statements provided by client #1 for a personal account that he had access to via an automated teller machine (ATM)</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 6</p> <p>card and receives monthly \$200.00 child support deposits revealed: -Client #1 received a \$200.00 deposit on 9/1/21 and a deposit for \$200.00 on 11/1/21. -Both statements had a recurring transfer of \$124.00 (on the same day as the deposit) into a savings account belonging to the Licensee.</p> <p>Reviews between 12/15/21 and 1/4/22 of the joint residential fund checking account for client #1, client #2 and 3 clients (client A1, client A2 and client A3) at sister facility A and deposits into the account identified by the Licensee revealed the following deposits for client #1: -Deposits for \$8,465.00 on 9/24/20 and \$445.00. -Deposits on 10/2/20 for \$1029.00 and 10/13/20 for \$27.00. -Deposits on 11/3/20 for \$1032.00 and 11/4/20 for \$445.00. -Deposits on 12/3/20 for \$445.00, 12/3/20 for \$1032.00 and 12/31/20 for \$896.00. -Deposits on 1/4/21 for \$600.00, 1/7/21 for \$4.00 an 1/21/21 for \$148.50. -Deposits on 2/3/21 for \$4.00 and 2/3/21 for \$1045.00. -Deposits on 3/3/21 for \$4.00 and 3/3/21 for \$1045.00. -Deposits on 4/2/21 for \$1045.00, 4/7/21 for \$1400.00 and 4/8/21 for \$4.00. -Deposits on 5/3/21 for \$1045.00 and 5/5/21 for \$4.00. -Deposits on 6/3/21 for \$1045.00 and 6/3/21 for \$4.00. -Deposits on 7/2/21 for \$1045.00, 7/8/21 for \$4.00 and 7/29/21 for \$12,565.28. -Deposits on 8/3/21 for \$1045.00 and 8/4/21 for \$4.00. -Deposits on 9/3/21 for \$1045.00 and 9/3/21 for \$4.00. -Deposits on 10/1/21 for \$1045.00 and 10/4/21</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 7</p> <p>for \$4.00. -A deposit on 11/1/21 for \$1045.00.</p> <p>Reviews between 12/15/21 and 1/4/22 of joint residential fund checking account statements, for client #1, client #2 and 3 clients (client A1, client A2 and client A3) at sister facility A, from 9/1/20-11/30/21 and revealed the following transfers and withdrawals:</p> <ul style="list-style-type: none"> -Transfer on 9/23/20 to the facility business account for \$5,944.03. -Transfer on 11/5/20 to the facility business account for \$21,235.06. -Transfer on 12/21/20 to the facility business account for \$6,373.03. -Transfer on 1/22/21 to the facility business account for \$8,035.43. -Transfer on 2/26/21 to the facility business account for \$6,394.25. -Transfer on 3/26/21 to the facility business account for \$6,011.51. -Transfer on 4/19/21 to the facility business account for \$13,003.50. -Transfer on 6/2/21 to the facility business account for \$18,249.98. -Transfer on 7/6/21 to the facility business account for \$7,036.72. -Transfer on 8/5/21 to the residential fund checking account for \$50,000; Transfer to the facility business account for \$60,000.00. -Transfer on 10/22/21 to the facility business account for \$14,000.00 -A check for \$1,000.00 on 10/8/21. -A check for \$1,000.00 on 11/18/21. -Residential fund checking account balance on 12/15/21 was \$18,261.88. <p>Interviews between 12/15/21 and 1/4/22 Client #1 stated: -He had a "bucket list" of things he wanted do do.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 8</p> <ul style="list-style-type: none"> -The 2 game consoles that were in the facility game room belonged to the facility and were not his. -He knew that he had received a lot of money but did not know how much. -He was given "\$1,000" in cash after taking his settlement check to the bank. -He kept some receipts. -He wanted staff #2/Licensee's spouse to attend the nascar race in a nearby city 225 miles away from the facility on 10/9/21-10/10/21 with him. -He thought "he paid for everyone" to go to the monster truck bash and the car race. -He enjoyed both trips. -Everyone is nice to him and he loved living at the facility. <p>Interview on 1/4/22 staff #2/Licensee's spouse stated:</p> <ul style="list-style-type: none"> -He had worked at the facility for 5 years. -Client #1 asked him to accompany him to the nascar race on 10/9/21-10/10/21 in a nearby city 225 miles from the facility. -The Licensee/his spouse paid for the hotel and tickets for him to attend the monster truck bash on 8/14/21-8/15/21 and the nascar race on 10/9/21-10/10/21 that were both 225 miles from the facility. -He was reimbursed for mileage and thought it was from the facility business account. -He was not asked to pay for his own hotel stay, but he paid for his own food. -He thought the facility purchased the two game systems in the game room at the facility, but does not know which client the game systems belong to. <p>Interviews between 12/17/21-1/4/22 the Clinical Director stated:</p> <ul style="list-style-type: none"> -She worked for the facility for 8 years. 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 9</p> <ul style="list-style-type: none"> -She did not pay for expenses for the monster truck trip that she attended with client #1. -She had not been reimbursed for mileage for the trip. -Client #1 wanted her to go to the monster truck bash, so she went. -Client #1 had been aware of the amount of his settlement and of the disability payment. -Client #1 wanted his family to go on the trips with him but he could not reach them by phone. -Client #1 was "excited and happy that he was able to do that for everyone." -She did not feel client #1 had been exploited "because it was his money, trips that he wanted to take and he wanted to pay for everyone to go." <p>Interviews between 12/15/21 and 1/4/22 the Licensee stated:</p> <ul style="list-style-type: none"> -Client #1 wanted to go to a monster truck bash and he wanted to pay for her (Licensee), staff #2/Licensee's spouse, Licensee's minor child, the Clinical Director and client #2 to attend. -Client #1 wanted to go to a nascar race and wanted staff #2/Licensee's spouse to attend with him. -Client #1 wanted to pay for everyone to accompany him on the trips. -She thought "it was fine since it was his money and his right" to do so. -Client #1 paid for the hotel stays, food and souvenir expenses but did not pay for tickets to the events. -Client #1 paid for [staff #2's/Licensee's spouse] mileage "because he wanted [staff #2/Licensee's spouse] to take him on the trips." -Two different game systems were purchased for client #1. -The personal funds for Client #1, client #2, and 3 clients from sister facility A are all deposited into a joint residential fund account and she had 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 10</p> <p>transferred the clients room and board and expenses from this account into the facility business account.</p> <p>-Client #1 received "\$2,000.00 cash" back after the deposit of his \$14,565.28 settlement check into the joint residential fund account where client #1, client #2 and 3 clients from sister facility A are also deposited.</p> <p>-Client #1 gradually spent the \$2,000.00, but the facility did not assist him with keeping receipts.</p> <p>-Client #1 received "\$200.00 child support per month" by direct deposit into an account that client #1 maintained a debit card for. "\$120.00 is automatically transferred to the facility business account for [client #1's] room and board expenses."</p> <p>-Client #1's room and board costs \$1410.00 monthly.</p> <p>-As of 12/16/21 client #1 had \$4,492.95 personal funds in the joint residential fund checking account for client #1, client #2 and 3 clients from a sister facility.</p> <p>-She "may not have transferred the clients room and board and the facility expenses every month."</p> <p>-She did not have accounting documentation to determine each client's balance, to support the checks and online transfers from the residential fund account for 9/1/20-11/30/21.</p> <p>-The various transfers amounts from the joint residential fund account for client #1, client #2 and 3 clients from sister facility A covered room and board and facility expenses for 2 facilities.</p> <p>Review on 12/17/21 of the Plan of Protection dated 12/17/20 written by the Licensee revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? We will research the process of developing</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	<p>Continued From page 11</p> <p>individual residential fund accounts for each member at mhl-040-018. We will designate Board Member [board member], as the authorizer of funds withdrawals for members [client #1] and [client #2], until the resolution of this survey.</p> <p>- "Describe your plans to make sure the above happens. Develop a financial Committee and provide a quarterly review report of revenues and expenditures. Finance Committee will meet, as needed to ensure that the administrative actions noted above are in compliance. [Board member] will be the person who implements this plan."</p> <p>The facility had 2 male clients, both 41 years old, with diagnoses which included Intellectual Developmental Disability-Mild, Bipolar Disorder-Severe, Intermittent Explosive disorder, Tobacco use Disorder, Intellectual Developmental Disability-Moderate, Hypertension, End Stage Renal Disease Stage- On dialysis, Chronic Kidney Disease Stage III, Acute Gout of Right Knee, Synovitis & Tenosynovitis of right ankle and foot. Client #1 had received 2 lump sum payments that totaled \$23,030.28 between 10/8/20 and 7/29/21. Client #1 had been given \$2,000 in cash on 7/29/21 that he gradually spent but only maintained receipts that totaled \$59.52 leaving \$1940.48 unaccounted for. Client #1 had discussed two events that he wanted to attend that required a staff accompanying him, overnight stays and meals. The Licensee used client #1's personal funds to pay for hotel stays that totaled \$2,455.27 for himself, client #2, Licensee, Licensee's minor child, Staff #2/Licensee's Spouse and the clinical director. Client #1's personal funds were also used to pay for another hotel stay for himself and staff #2 that cost \$278.03. Staff #2/Licensee's Spouse was reimbursed for travel that totaled \$450.00 that was also deducted from client #1's personal</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 512	Continued From page 12 funds. Receipts dated 10/9/21 revealed client #1's personal funds were used for 3 separate meal purchases for 2 people that totaled \$88.61. \$1,411.21 of client #1's personal funds were used to purchase 2 game consoles, game controllers, games and protection plans that client #1 stated were not his and belonged to the facility. Receipts revealed that client #1's personal funds were used to purchase 2 TVs and 2 protection plans in one transaction that was \$449.96, 2 pairs of shoes that were the same color and not client #1's shoe size that were \$139.10 each. This deficiency constitutes a Type A1 rule violation for serious exploitation and must be corrected within 23 days. An administrative penalty of \$2,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money;	V 542		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 542	<p>Continued From page 13</p> <p>(2) regulate the receipt and distribution of funds in a personal fund account;</p> <p>(3) provide for the receipt of deposits made by friends, relatives or others;</p> <p>(4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account;</p> <p>(5) assure that a client's personal funds will be kept separate from any operating funds of the facility;</p> <p>(6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client;</p> <p>(7) provide for the issuance of receipts to persons depositing or withdrawing funds; and</p> <p>(8) provide the client with a quarterly accounting of his personal fund account.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to (1) manage and maintain records of client personal funds as required; (2) keep clients' personal funds separate from any operating funds (3) provide quarterly accounting of clients' personal fund accounts, (4) provide for the issuance of receipts to persons depositing or withdrawing funds affecting 2 of 2 clients (#1, #2). The findings are:</p> <p>Finding #1 Review on 12/15/21 of client#1's record revealed: -41 year old male admitted 8/1/02. -Diagnoses of Intellectual Developmental Disability-Mild, Bipolar Disorder, Intermittent Explosive disorder and Tobacco use Disorder.</p>	V 542		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 542	<p>Continued From page 14</p> <p>-A consumer monthly funds report dated 9/1/17-12/4/21 with client #1's signature denoting \$76.00 given to him monthly.</p> <p>-No evidence of quarterly accounting of client #1's personal funds being provided to him.</p> <p>-Client #1's personal funds had been deposited into the joint residential fund account where personal monies for him, client #2 and 3 clients from sister facility A were deposited monthly.</p> <p>-No evidence of receipts for withdrawals from client #1's personal funds.</p> <p>Finding #2 Review on 12/15/21 of client #2's record revealed:</p> <p>-41 year old male admitted 10/2/14.</p> <p>-Diagnoses included Bipolar Disorder, Hypertension, Synovitis, Tenosynovitis of right ankle and foot, Acute Gout of right Knee, End Stage Renal Disease on Dialysis and Chronic Kidney Disease Stage III-Moderate.</p> <p>-A consumer monthly funds report dated 9/1/17-12/4/21 with client #2's signature and denoted \$76.00 given to him with a phone bill expense of \$40.00 written on it from 10/1/18-12/4/21.</p> <p>-No evidence of quarterly accounting of client #2's personal funds being provided to the guardian.</p> <p>-Client #2's personal funds had been deposited into a joint residential fund account where client #1's and 3 clients (client A1, client A2 and client A3) from sister facility A's personal funds were also deposited monthly.</p> <p>Interview on 12/15/21 Client #1 stated:</p> <p>-He had lived at the facility for 20 years.</p> <p>-He is his own guardian.</p> <p>-He normally had \$80.00 to spend monthly.</p> <p>-He has a savings account with about \$22.00 in it</p>	V 542		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 542	<p>Continued From page 15</p> <p>and he receives statements for it at the facility.</p> <p>-He had been in a vehicle accident and received a settlement that was a lot of money but did not know how much.</p> <p>-He took the the settlement check to the bank and kept \$1,000 that he bought clothes with.</p> <p>-He went to see a monster truck bash and a nascar race.</p> <p>-The Licensee, Staff #2/Licensee's spouse, Licensee's minor daughter, client #2 and the Clinical Director accompanied him to the monster truck bash on 8/14/21-8/15/21, 225 miles from the facility and they all stayed at a hotel.</p> <p>-Staff #2/Licensee's spouse had accompanied him to the nascar race on 10/9/21-10/10/21 225 miles from the facility and they stayed in a hotel.</p> <p>-He has only ever had 2 pair of sneakers that were branded, they were not orange/white/black and he bought them.</p> <p>-He was not aware who paid for the monster truck and nascar expenses but thought it was paid "with his money."</p> <p>-He had never received a quarterly accounting of his personal funds.</p> <p>-He was not sure how much money he currently had.</p> <p>Interview on 12/15/21 Client #2 stated:</p> <p>-He enjoyed living at the facility.</p> <p>-He received \$66.00 every month from the Licensee.</p> <p>Interview on 1/4/22 Staff #2/Licensee's spouse stated:</p> <p>-He went with client #1 to the monster truck bash and the nascar race.</p> <p>-He was reimbursed for mileage in the amount of \$450.00 for both trips.</p> <p>-The Licensee had paid for the hotel stays, admission and mileage cost.</p>	V 542		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 HIGHWAY 58 NORTH SNOW HILL, NC 28580
--	--

(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 542	<p>Continued From page 16</p> <p>-He was not asked to pay for any of the expenses himself.</p> <p>Interview between 12/15/21-1/4/22 the Licensee stated:</p> <p>-She was not aware clients and guardians were required to receive a quarterly accounting of their accounts.</p> <p>-Quarterly accounting statements were not provided to clients or guardians.</p> <p>-Clients were responsible for maintaining their personal money and any receipts.</p> <p>-Client #1 signed his monthly fund report for receipt of \$76.00 monthly but had actually received \$80.00 per month.</p> <p>-\$120 was automatically transferred to the facility business account from the account that client #1 received his monthly \$200.00 child support deposit.</p> <p>-All of client #1 and client #2's personal funds were deposited into a joint residential fund account with 3 other clients from sister facility A.</p> <p>This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation V512 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 542		