	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
					R	ł
		MHL040030	B. WING		02/0	4/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LUCILLE	'S BEHAVIORAL, INC	こ 世フ	OMAN ROANBURG, NC			
(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 000	INITIAL COMMENT	-S	V 000			
	2022. Deficiencies of This facility is licens category: 10A NCA Living for Adults with A sister facility is idensister facility will be	was completed February 4, were cited. sed for the following service AC 27G .5600C, Supervised h Developmental Disabilities. entified in this report. The identified as sister facility A be identified as client A1, client				
V 400	A2 and client A3. The survey sample current clients.	consisted of audits of 3	V 108			
V 106	10A NCAC 27G .02 REQUIREMENTS (f) Continuing eduction (g) Employee training provided and, at a resolution following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathogon (h) Except as perminus 5602(b) of this Submember shall be available training seizure minus member shall be training seizure minus member shall be training seizure minus member seizure minus minus minus minus minus minus minus member seizure minus min	cation shall be documented. Ing programs shall be minimum, shall consist of the rational orientation; It rights and confidentiality as CAC 27C, 27D, 27E, 27F and If the mh/dd/sa needs of the In the treatment/habilitation	V 108			

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

TITLE (X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL040030	B. WING		F-02/0	R 4/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/0	7/2022
LUCILLE	S'S BEHAVIORAL, INC	351 HOLL	OMAN ROA	D		
		WALSTON	NBURG, NC		201	0.47
(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 108	Continued From pa	ge 1	V 108			
	techniques such as the American Heart equivalence for relie (i) The governing b implement policies reporting, investigat	lich maneuver or other first aid those provided by Red Cross, Association or their eving airway obstruction. ody shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and				
	failed to ensure star Cardiopulmonary R Aid (FA) affecting 1 Review on 2/3/22 or revealed: -A hire date of 9/14/- -National CPR Four dated 9/11/20 for C -There was no evid Aid Certification that in-person instructor Interview on 2/3/22 -Staff #1 was hired	view and interview, the facility ff were trained in esuscitation (CPR) and First of 3 staff audited (#1). of staff #1's personnel record /20. Indation training certificate PR and First Aid. ence of a current CPR or First at had been conducted with an				
V 542	27F .0105(a-c) Clie Funds	nt Rights - Client's Personal	V 542			
	10A NCAC 27F .01	05 CLIENT'S PERSONAL				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL040030	B. WING		02/0	R 04/2022
	PROVIDER OR SUPPLIER	351 HOLL	ORESS, CITY, S OMAN ROA IBURG, NC			
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 542	FUNDS (a) This Rule application typically provides reclients for more than (b) Each competer above the age of 16 encouraged to main personal fund accompeter above the age of 16 encouraged to main personal fund accompeter at the control of the co	es to any 24-hour facility which esidential services to individual in 30 days. In adult client and each minor is shall be assisted and intain or invest his money in a unit other than at the facility. But need not be limited to, is in interest-bearing accounts. In aged for a client by a facility ment of the funds shall occur policy and procedures that: the client the right to deposit by; the receipt and distribution of fund account; for the receipt of deposits made a or others; for the keeping of adequate a all transactions affecting personal fund account; at a client's personal funds will form any operating funds of the fund the deduction from a funt payment for treatment or is when authorized by the client the person upon or subsequent client; for the issuance of receipts to or withdrawing funds; and the client with a quarterly personal fund account.	V 542			
	This Rule is not me Based on record re	et as evidenced by: views and interviews, the				

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STATE FORM 6899 CVGO11 If continuation sheet 3 of 10

AND DI AN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL040030	B. WING			R 04/2022
	PROVIDER OR SUPPLIER	351 HOLL	DRESS, CITY, S OMAN ROA NBURG, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 542	facility failed to (1) rof client personal fur operating funds (3) of clients' personal the issuance of receivithdrawing funds and #3). The finding #1 Review on 2/2/22 or -43 year old female -Diagnoses of Schit Compulsive Disord Intellectual Develop Hypertension, Gast -A consumer month - 1/2022 with client \$76.00 given to her -No evidence of quipersonal funds being -No evidence of received funds in January 20 for client #2 received funds in January 20 for \$1400.00Client #2 received \$696.93 in February 2021, \$768. 50 and in June 2021. Client monthly between Ju-Client #2 received (EBT) funds monthly	manage and maintain records ands as required; (2) keep ands separate from any provide quarterly accounting fund accounts, (4) provide for eipts to persons depositing or affecting 3 of 3 clients (#1, #2 gs are: If client# 2's record revealed: admitted 11/21/17. zophrenia, Obsessive er, Diabetes-Type A, omental Disability-Mild, roesophageal Reflux Disease ally funds report dated 11/2020 #2's signature denoting monthly. arterly accounting of client #2's ag provided to her guardian. seipts for withdrawals from	V 542			

Division of Health Service Regulation

STATE FORM 6899 CVGO11 If continuation sheet 4 of 10

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		MHL040030	B. WING		F 02/0	R 94/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LUCILLE	E'S BEHAVIORAL, INC	: #7	OMAN ROA IBURG, NC			
(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)	JLD BE	(X5) COMPLETE DATE
V 542	2021. Interview on 2/3/22 -She had lived at th -She received \$76.0 moneyShe had never rec statementShe kept and sper all receipts. Finding #2 Review on 2/2/22 o -52 year old male a -Diagnoses of Intell Disability-Profound, ConstipationNo evidence of qua personal funds beir -No evidence of rec client #1's personal Review on 2/2/22 - statements for 1/1/2 residential fund acc for client #1, client #1 sister facility A were -Client #1 received funds in January 20 for \$1400.00 -Client #1 received \$794.00 monthly 2/ -Client #1 received funds monthly betw amount of \$454.00.	client #2 stated: e facility 5-6 years. 00 monthly as personal eived a quarterly accounting at her money but did not retain f client #1's record revealed: dmitted 3/31/09. ectual Developmental High Cholesterol and arterly accounting of client #1's ag provided to his guardian. eipts for withdrawals from funds 2/3/22 of facility bank 21 - 11/30/21 of a joint count where personal monies #2, client #1 and 2 clients from deposited monthly revealed: deposits of personal stimulus 21 for \$600.00 and April 2021 social security deposits of 1/21 - 11/30/21. electronic benefits transfer een 1/1/21 - 11/30/21 in the	V 542			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL040030	B. WING		02/0	R 04/2022
NAME OF PROVIDER OR SUPPLIER LUCILLE'S BEHAVIORAL, INC. #2 STREET ADDRESS, CITY, STATE, ZIP CODE 351 HOLLOMAN ROAD WALSTONBURG, NC 27888						
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 542	Review on 2/2/22 or -59 year old female Diagnoses of Schiz Intellectual Develop Nicotine Dependent Disease, Diabetes I Dysfunction, Benigrand Anemia. -No evidence of quapersonal funds beirnous evidence of recilient #3's personal Review on 2/2/22 - statements for 1/1/2 residential fund according for client #3, client #3 received funds in January 20 \$1400.00. -Client #3 received funds monthly 2/2-Client #3 received funds monthly between amount of \$454.00. Interview on 2/2/22 monthly spending in the community and in the community and Interview on 2/3/22 - She had never received stated: -Quarterly accounting provided to clients of services of states.	f client #3's record revealed: admitted 9/3/08. ophrenia-Paranoid Type, omental Disability-Mild, ce, Gastroesophageal Reflux Mellitus, Cholesterol ochest Lumps in Lung Area arterly accounting of client #3's ing provided to her guardian. seipts for withdrawals from funds. 2/3/22 of facility bank 21 - 11/30/21 of a joint count where personal monies #1, client #2 and 2 clients from a deposited monthly revealed: deposits of personal stimulus 21 for \$600.00 and April for social security deposits of 1/21 - 11/30/21. electronic benefits transfer reen 1/1/21 - 11/30/21 in the client #3 stated she received noney, she regularly shopped and she kept her money. client #2's guardian stated: eived a quarterly accounting facility. 2/2/22 - 2/4/22 the Licensee ang statements were not	V 542			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL040030	B. WING		F 02/0	R 14/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 02/0	-112022
		351 HOLL	OMAN ROA			
LUCILLE	E'S BEHAVIORAL, INC	. #2 WALSTON	NBURG, NC	27888		
(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 APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 542	Continued From pa	ge 6	V 542			
	funds were deposite	ey and any receipts. nt #2, and client #3's personal ed into a joint residential fund r clients from sister facility A.				
V 543	27F .0105(d) Client Funds	Rights - Client's Personal	V 543			
	responsible person can be made from a any amount owed condamages done or a the client: (1) to the facility (2) an employ (3) to a visitor	y the client or legally is required before a deduction a personal fund account for or alleged to be owed for lleged to have been done by				
	facility failed to rece or legally responsib was made from clie any amount owed o	et as evidenced by: view and interviews, the sive authorization by the client le person before a deduction nt's personal fund account for or alleged to be owed for the client for 1 of 3 clients (#2).				
	-43 year old female -Diagnoses of Schiz Compulsive Disordo Intellectual Develop Hypertension, Gast	f client# 2's record revealed: admitted 11/21/17. zophrenia, Obsessive er, Diabetes-Type A, mental Disability-Mild, roesophageal Reflux Disease. al guardian through a local				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		F	,
		MHL040030	B. WING			4/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUCILLE	S BEHAVIORAL, INC	: # 2	.OMAN ROA NBURG, NC			
(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 543	Continued From pa	ge 7	V 543			
	advocacy agency.					
	statements for 1/1/2 residential fund acc for client #2, client sister facility A were -Client #2 received funds in January 20 for \$1400.00. Review on 2/2/22 - 6/10/21 revealed: -The invoice had th from a flooring com-"Description- Insta	2/3/22 of facility bank 21 - 11/30/21 of a joint count where personal monies #1, client #3 and 2 clients from e deposited monthly revealed: deposits of personal stimulus 021 for \$600.00 and April 2021 2/3/22 of an invoice dated e facility's address and was apany in a neighboring city. Il roll goods (stock selection) hove and dispose of existing				
	carpet/padding cos remove stapleses of for (2) doors cost \$	t \$118.00prep floor and cost \$125.00, install thresholds 25.00Install primed quarter 0.00-cost \$2.00, total \$240.00."				
	whole house needer. The floors had been facility so it would "I her money did not sometime. She would sometime can in her bedroom	acility were cracked up ad the ed floors replaced. en replaced throughout the look nice." It pay to replace the floors. mes relieve herself in a trash if someone else was in the never relieved herself on the				
	-She had been clied years inconsistently -She was aware of -She had not been	client #2's guardian stated: nt #2's guardian for about 2 /. client #2's incontinence issue. contacted by anyone from the the use of client #2's personal				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL040030	B. WING		02/0	₹ 4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUCILLE	E'S BEHAVIORAL, INC	こ サン	OMAN ROA			
LOGILLE		WALSTO!	NBURG, NC	27888		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 543	Continued From pa	age 8	V 543			
	funds to pay for any caused by client #2 -She would have exapproval for client produced by case basis and case by case basis and case by case some cases client and case to pay for danger in the carpet in client up because client freesThe carpet turned	y damages at the facility 2. valuated the situation and and personal funds to pay for by clients is considered on a second personal funds had been mages caused by them. If the Group Home Manager at #2's closet had to be pulled #2 had soiled it with urine and brown. It installed because the urine				
	-Client #2 had a legadvocacy agencyClient #2 had recefor \$1400.00 that we residential fund acclient #1, client #3 a A personal funds at a client #2 ruined he continuously urinatifloor having to be reclient #2's \$1400.0 was used to pay for closet floor since clent #2's inapprobeen discussed with with the local mana -She had not discusfunds to pay for dather bedroom closes -She had not received.	er bedroom closet floor by ing on it resulting in the closet				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL040030			F 02/0	R 4/2022
NAME OF I					02/0	4/2022
	PROVIDER OR SUPPLIER	351 HOLL	OMAN ROA	STATE, ZIP CODE .D		
LUCILLE	'S BEHAVIORAL, INC	 	NBURG, NC			
(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 543	Continued From pa	ge 9	V 543			
V 543		ment of of the closet floor in	V 543			

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