

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL002-028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2022
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NAME OF PROVIDER OR SUPPLIER LUCA'S HOPE III	STREET ADDRESS, CITY, STATE, ZIP CODE 243 LILEDOUN ROAD TAYLORSVILLE, NC 28681
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V 000	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on February 10, 2022. The complaint was unsubstantiated (Intake #NC00184216). Deficiencies were cited.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.</p> <p>The survey sample consisted of audits of two current clients and one former client.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to hold fire and disaster drills at least quarterly and for each shift. The findings are:</p> <p>Review on 2-7-22 of facility fire and disaster drill</p>	V 114		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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V 114	<p>Continued From page 1</p> <p>records revealed:</p> <ul style="list-style-type: none"> -For first quarter 2021 (January, February, and March): <ul style="list-style-type: none"> -Fire drills were not completed for 2nd and 3rd shifts. -Disaster drills were not completed for 1st shift. -For the third quarter 2021 (July, August, and September): <ul style="list-style-type: none"> -Fire drills were not completed for 2nd and 3rd shifts. -Disaster drills were not completed for 1st shift. -For the fourth quarter 2021 (October, November, and December): <ul style="list-style-type: none"> -Fire drills were not completed for 1st shift. -Disaster drills were not completed for 2nd shift. <p>Interview on 2-7-22 and 2-8-22 with the Director revealed:</p> <ul style="list-style-type: none"> -There are three shifts: first, second, and third. -The facility was closed the first two months of 2021. -It has been hard to get staff and "we just do what we can". -May have the missing drills at the office. There is some paperwork that has to be filed. 	V 114		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY</p> <p>(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section.</p>	V 132		

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V 132	<p>Continued From page 2</p> <p>(which includes:</p> <ul style="list-style-type: none"> a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). <p>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by:</p>	V 132		

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V 132	<p>Continued From page 3</p> <p>Based on record reviews and interviews, the facility failed to notify the Department of allegations and report results of investigation of an allegation against health care personnel. The findings are:</p> <p>Interview on 2-8-22 with Department of Social Services (DSS) Social Worker regarding allegation of neglect of a client for improper discipline by a staff person revealed: -The Director knew the allegations against the specific staff when the DSS report was initiated. -DSS did not make the recommendation that Staff #1 not work in the facility but had discussions with the Director and Staff #1 about no physical discipline for the clients. -All clients denied allegations and the client who initially made the allegation recanted his story. -The DSS case was closed with Services Not Recommended.</p> <p>Interview on 2-9-22 with the Qualified Professional (QP) revealed: -Was not aware that a report to Health Care Personnel Registry (HCPR) had to be made for an allegation. -"In the past we have made the report to DSS. That is all we were told we were supposed to do."</p> <p>Interview on 2-7-22 and 2-8-22 with the Director revealed: -The Director was aware of the DSS report and the allegations that a staff had whipped a client. -No specific staff was mentioned initially from the report. -She was able to figure out which staff the allegation was about after the clients were interviewed. -A report to HCPR was not done as the Director was waiting for Division of Health Service</p>	V 132		

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V 132	<p>Continued From page 4</p> <p>Regulation (DHSR) to come out to complete an investigation.</p> <p>-"I didn't want to report someone to HCPR if the allegations were not true."</p> <p>-She had spoken to Staff #1 but had not documented any conversations.</p> <p>-"I'm not even sure how to make a report to HCPR."</p> <p>-Did not complete a North Carolina Incident Response Improvement System (IRIS) report or any formal internal investigation. "I talked with her (Staff #1) about it."</p> <p>-"DSS didn't tell me that she (Staff #1) couldn't work but I wouldn't let her work until DHSR came out to complete the investigation and say she could return to work."</p> <p>Record review on 2-7-22 and 2-8-22 revealed:</p> <p>-No documentation of a report made to the HCPR.</p> <p>-No documentation of an internal investigation.</p> <p>This deficiency constitutes a re-cite deficiency and must be corrected within 30 days.</p>	V 132		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 5</p> <p>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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 6</p> <p>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:</p> <ol style="list-style-type: none"> (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; (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. <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level 2 incidents that occurred during the provision of billable services.</p>	V 367		

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V 367	<p>Continued From page 7</p> <p>The findings are:</p> <p>Review of records on 2-7-22 and 2-8-22 revealed: -No evidence of an incident report related to the allegations against staff #1. -No evidence of an internal investigation completed by the facility.</p> <p>Interview on 2-8-22 with Department of Social Services (DSS) Social Worker revealed: -the Director knew the allegations against the specific staff when the DSS report was initiated. -DSS did not make the recommendation that Staff #1 not work in the facility but had discussions with the Director and Staff #1 about no physical discipline for the clients.</p> <p>Interview on 2-9-22 with the Qualified Professional (QP) revealed: -Documentation was completed in the form of monthly supervision notes with staff #1. -She believed an incident report had been completed. The Director should have completed it.</p> <p>Interview on 2-7-22 and 2-8-22 with the Director revealed: -She had spoken with Staff #1 but had not documented any conversations. -Did not complete a North Carolina Incident Response Improvement System (IRIS) report or any formal internal investigation. "I talked with her (Staff #1) about it."</p> <p>This deficiency constitutes a re-cite deficiency and must be corrected within 30 days.</p>	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance	V 736		

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V 736	<p>Continued From page 8</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to be maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observations on 2-7-22 at 12:30 pm and 2-8-22 at 10:15 am revealed: -Blinds in the client bathroom were missing 3-4 slats. -Blinds in the living room covering 3 windows had multiple slats that were broken and hanging in the holding strings and some slats were missing. -Blinds in one of the kitchen windows had 2 broken slats.</p> <p>Interview on 2-8-22 with the Director revealed: -One of the clients like to "snap the blinds." The clients look out of the window between the slats. -Would have to replace the blinds every two months due to how often the clients break them. -Need to get something more durable that will last.</p>	V 736		