Division of Health Service Regulation

PRINTED: 02/28/2022
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL002-028	A. BUILDING: ______ B. WING ______	R 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCA'S HOPE III	243 LILEDOUN ROAD TAYLORSVILLE, NC 28681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on February 10, 2022. The complaint was unsubstantiated (Intake #NC00184216). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. The survey sample consisted of audits of two current clients and one former client.	V 000	Luca's Hope will set up a monthly monitoring system to review the Fire & disaster drills to ensure that the Facility IS holding Fire & disaster drills quarterly and on each shift. The Director will be responsible Checking & enforcing this to be done. The Facility will Implement a Quarterly Checklist that includes Fire & disaster drills.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (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. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (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. (d) Each facility shall have basic first aid supplies accessible for use. 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: Review on 2-7-22 of facility fire and disaster drill	V 114	DHSR - Mental Health MAR 9 2022 Lic. & Cert. Section	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] 3/5/22

TITLE: Executive Director

(X6) DATE

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V 114	Continued From page 1 records revealed: -For first quarter 2021 (January, February, and March): -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): -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): -Fire drills were not completed for 1st shift. -Disaster drills were not completed for 2nd shift. Interview on 2-7-22 and 2-8-22 with the Director revealed: -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	V132 Lucas Hope will Conduct a Class at the next STAFF meeting updating & educating all staff are aware of the rules that apply to the Health CAre personnel Registry. The Facility will document the inhouse Investigations Completed by administration so that this will be available For review at anytime showing as proof that an Internal Investigation has been Conducted. The operations manager will be responsible For ensuring this Is implemented, the Facility will ensure that all Incidents that match requirements To report on the (IRIS) within the required time Frame to remain In Compliance. Luca's Hope has reported the allegation to the HealtCAre Personnel Registry since this survey From DHSR has been Conducted	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (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.	V 132		

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V 132	Continued From page 2 (which includes: 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). 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. This Rule is not met as evidenced by:	V 132		

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V 132	Continued From page 3 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: 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. 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." 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	V 132		

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V 132	Continued From page 4 Regulation (DHSR) to come out to complete an investigation. -"I didn't want to report someone to HCPR if the allegations were not true." -She had spoken to Staff #1 but had not documented any conversations. -"I'm not even sure how to make a report to HCPR." -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." -"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." Record review on 2-7-22 and 2-8-22 revealed: -No documentation of a report made to the HCPR. -No documentation of an internal investigation. This deficiency constitutes a re-cite deficiency and must be corrected within 30 days.	V 132		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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V 367	Continued From page 5 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III	V 367		

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V 367	Continued From page 6 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level 2 incidents that occurred during the provision of billable services.	V 367	V 367 Luca's Hope will ensure that all Incidents of all required Levels be reported & Documented according to the rules that apply to incident reporting. The Facility will also ensure that the internal Investigations are documented and Filed so that the internal Investigation can be available For Review. Luca's Hope will designate the QP (QMHP) as the personnel being responsible For monitoring all Incidents and the process of completing Incident reports Forms. Luca's Hope will conduct an Incident reporting Refresher Class For all staff, reviewing the rules and whats required For all Levels of Incidents	

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V 367	Continued From page 7 The findings are: 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. 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. 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. 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." This deficiency constitutes a re-cite deficiency and must be corrected within 30 days.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance	V 736		

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V 736	Continued From page 8 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (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. 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: 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. 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.	V 736	V 736 Luca's Hope will do a monthly Inhouse Check of blinds to ensure that they are replaced If needed. The Director will be responsible For this montly Check. The Facility has replaced all blinds within the home. Luca's Hope changed all blinds purchasing a more durable type of blinds that won't be so easy to break. The home installed the hard plastic tye blinds throughout the home.	

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

DHSR - Mental Health

MAR 9 2022

Lic. & Cert. Section

March 1, 2022

Valarie Stanback
Luca's Hope, LLC
PO Box 442
Suite 307
Sherrills Ford, NC 28673

Re: Annual, Complaint, and Follow up Survey completed February 10, 2022
Luca's Hope III, 243 Liledoun Road, Taylorsville, NC 28681
MHL # 002-028
E-mail Address: valariestanback@yahoo.com
Intake #NC00182216

Dear Ms. Stanback:

Thank you for the cooperation and courtesy extended during the Annual, Complaint, and Follow up survey completed February 10, 2022. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is March 12, 2022.

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 11, 2022.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Sonia Eldridge at 828-665-9911.

Sincerely,

Benjamin Robinson
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant