Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING MHL040030 02/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 351 HOLLOMAN ROAD LUCILLE'S BEHAVIORAL, INC. #2 WALSTONBURG, NC 27888 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000 V 000 INITIAL COMMENTS A follow up survey was completed February 4, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities. 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. The survey sample consisted of audits of 3 current clients. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B: (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL040030 02/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 351 HOLLOMAN ROAD LUCILLE'S BEHAVIORAL, INC. #2 WALSTONBURG, NC 27888 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 3/8/2022 V 108 V 108 Continued From page 1 V108- Based on the record review, the facility failed to ensure staff were trained in the Heimlich maneuver or other first aid trained in Cardiopulmonary techniques such as those provided by Red Cross. the American Heart Association or their Resuscitation (CPR) and First Aid (FA) equivalence for relieving airway obstruction. affecting 1 of 3 staff audited (#1). (i) The governing body shall develop and implement policies and procedures for identifying, Findings: reporting, investigating and controlling infectious 1) Staff Billy Johnson was previously a and communicable diseases of personnel and clients Habtech for Caswell Developmental Center, a state facility, where he received CPR/First Aid training ongoing. 2) Mr. Billy took a class on-line for recertification when he was This Rule is not met as evidenced by: employed in September of 2020. Based on record review and interview, the facility failed to ensure staff were trained in 3) Because the Corporate Office was Cardiopulmonary Resuscitation (CPR) and First closed due to COVID 19 during two Aid (FA) affecting 1 of 3 staff audited (#1). weeks of January 2022, the First Review on 2/3/22 of staff #1's personnel record Aid/CPR training was postponed to a revealed: later late than originally scheduled. A hire date of 9/14/20. -National CPR Foundation training certificate We advised Officer Grant from DHSR dated 9/11/20 for CPR and First Aid. that we had the training scheduled -There was no evidence of a current CPR or First for 2/4/2022 or 2/5/2022. Aid Certification that had been conducted with an in-person instructor. Staff received CPR and First Aid training by Amy Smith who is a Interview on 2/3/22 the Licensee stated: Certified CPR/First Aid Trainer with -Staff #1 was hired in 2020 and completed the CPR/FA certification online because of the the American Health and Safety pandemic. Institute on 2/4/2022. V 542 V 542 27F .0105(a-c) Client Rights - Client's Personal Funds

Division of Health Service Regulation

10A NCAC 27F .0105

CLIENT'S PERSONAL

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: (X3) DATE		SURVEY LETED				
			7. DOLDING.		R			
MHL040030		B. WING		02/04/2022				
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
LUCILLE	LUCILLE'S BEHAVIORAL, INC. #2 351 HOLLOMAN ROAD							
LUCILLE	3 BEHAVIORAL, INC	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 APPROVIDENCY)	D BE COMPLETE			
V 542	Continued From pa	ge 2	V 542	Annual trainings are scheduled	and	3/8/2022		
	FUNDS			the time, date, location and co	ntent			
	(a) This Rule applie	es to any 24-hour facility which		are distributed to employees				
		sidential services to individual		through email and at staff mee	tings			
	(b) Each competer	n 30 days. ht adult client and each minor		throughout the year.				
		shall be assisted and		 We will continue to utilize our				
		ntain or invest his money in a		annual personnel training caler	ndar			
	•	unt other than at the facility.		to ensure that trainings are				
		out need not be limited to, in interest-bearing accounts.		conducted on time.				
	(c) If funds are ma employee, manage	naged for a client by a facility ment of the funds shall occur		V542-Personal funds				
		policy and procedures that:		The facility has adopted the att	ached			
	 assure to and withdraw mone 	the client the right to deposit		Financial Management Policy a				
		he receipt and distribution of		Procedure to comply with 10A	NCAC			
	funds in a personal	fund account;		27D.0304 and with 10A NCAC 2	27F			
		r the receipt of deposits made		.0105 for the management of,				
	by friends, relatives			accounting for, and protection	of the			
	(4) provide for the keeping of adequate financial records on all transactions affecting			personal funds of the clients.				
		personal fund account; at a client's personal funds will		The facility will conduct training	g on			
	* *	om any operating funds of the		the policy with the manageme	nt,			
	facility;	on any operating rando or the		ownership, board, and all perso	ons			
		r the deduction from a		assisting clients in the manage	ment			
		unt payment for treatment or		of their personal funds. The fac	cility			
		when authorized by the client le person upon or subsequent		will abide by the Financial				
	to admission of the			Management Policy and Proce				
		or the issuance of receipts to		in all instances in which the fac	′ 1			
	persons depositing or withdrawing funds; and			assists a client with the manage	ement			
		e client with a quarterly ersonal fund account.		of client personal funds.				
	associating of the pr	erosamina avovant.		The facility has conducted a rev	view			
				and determined an accurate				
				accounting of the amount of ea	ach			
	This Rule is not my	at se avidancad by:		client's funds in the pooled acc				
	This Rule is not me Based on record re	views and interviews, the		·				

Division of Health Service Regulation STATE FORM

PRINTED: 02/18/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL040030 02/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 351 HOLLOMAN ROAD LUCILLE'S BEHAVIORAL, INC. #2 WALSTONBURG, NC 27888 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 3/8/2022 V 542 Continued From page 3 V 542 The representative payee for each client has opened separate bank facility failed to (1) manage and maintain records accounts for each client. of client personal funds as required; (2) keep clients' personal funds separate from any The facility has deposited into each operating funds (3) provide quarterly accounting of clients' personal fund accounts, (4) provide for separate bank account all money of the issuance of receipts to persons depositing or each client, that was in the pooled withdrawing funds affecting 3 of 3 clients (#1, #2 account, into that client's separate and #3). The findings are: bank account. Finding #1 The facility has adopted the attached Review on 2/2/22 of client# 2's record revealed: Financial Management Policy and -43 year old female admitted 11/21/17. Diagnoses of Schizophrenia, Obsessive Procedure to comply with 10A NCAC Compulsive Disorder, Diabetes-Type A. 27D.0304 and with 10A NCAC 27F Intellectual Developmental Disability-Mild. .0105 for the management of, Hypertension, Gastroesophageal Reflux Disease accounting for, and protection of the -A consumer monthly funds report dated 11/2020 - 1/2022 with client #2's signature denoting personal funds of the clients. \$76.00 given to her monthly. The facility will conduct training on -No evidence of quarterly accounting of client #2's personal funds being provided to her guardian. the policy with the Financial -No evidence of receipts for withdrawals from Management Policy, ownership, client #2's personal funds. board, and all persons assisting clients in the management of their Review on 2/2/22 - 2/3/22 of facility bank personal funds. The facility will abide statements for 1/1/21 - 11/30/21 of a joint residential fund account where personal monies by the Financial Management Policy for client #2, client #1, client #3 and 2 clients from and Procedure in all instances in sister facility A were deposited monthly revealed: which the facility assists a client with -Client #2 received deposits of personal stimulus the management of client personal funds in January 2021 for \$600.00 and April 2021 funds. for \$1400.00. Client #2 received social security deposits of \$696.93 in February 2021, \$768.19 in March 2021, \$768, 50 and \$785,72 in April and \$722,27 in June 2021. Client #2 received \$756.72 monthly between July 2021 and November 2021.

-Client #2 received electronic benefits transfer (EBT) funds monthly 1/1/21 - 10/30/21 in the amount of \$442.00 and \$411.00 for November

(X3) DATE SURVEY

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION		OF CORRECTION	IDENTIFICATION NUMBERS	A. BUILDING:		COMPLETED	
MHL040030		B. WING		R 02/04/2022			
LUCILLE'S REHAVIORAL INC #2 351 HOLL			#2 351 HOLL	ORESS, CITY, S OMAN ROA NBURG, NC			
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(XS) COMPLETE DATE
	V 542	moneyShe had never recistatementShe kept and spen all receipts. Finding #2 Review on 2/2/22 or -52 year old male a -Diagnoses of Intell Disability-Profound, ConstipationNo evidence of quapersonal funds beinty-No evidence of recibility and site of the client #1's personal residential fund according for \$140.00 -Client #1 received funds in January 20 for \$1400.00 -Client #1 received \$794.00 monthly 2/-Client #1 received funds monthly between 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 edeposited monthly revealed: deposits of personal stimulus 121 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	The facility has conducted a reviand determined an accurate accounting of the amount of eacilient's funds in the pooled accounts for each client. The representative payee for each client has opened separate bank accounts for each client. The facility has deposited into e separate bank account all mone each client, that was in the pool account, into that client's separate bank account. The Representative Payee will complete the necessary paperw with the Social Security Adminis for the direct deposit for each clien separate account. Until the direct deposit has been changed by the all monies deposited into the position account will be deposited in full each client's account and any disbursement, withdrawals or deductions will be made directly the client's individual account and managed in accordance with the facility's Financial Management	ch bunt. ach c ach y of ed ate ork tration lient to t's ct e SSA, poled into	3/8/2022

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
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MHL040030		B. WING		02/04/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	TIE DELIAMODAL ING	351 HOLL	OMAN ROA	D		
LUCILLE	E'S BEHAVIORAL, INC	#2 WALSTON	NBURG, NC	27888		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
V 542	Review on 2/2/22 or -59 year old female Diagnoses of Schiz Intellectual Develop Nicotine Dependen Disease, Diabetes Dysfunction, Benigrand Anemia. -No evidence of quipersonal funds beiring -No evidence of recident #3's personal Review on 2/2/22 - statements for 1/1/2 residential fund accident #3, client sister facility A were -Client #3 received funds in January 20 \$1400.00. -Client #3 received funds monthly 2/2 -Client #3 received funds monthly betwamount of \$454.00. Interview on 2/2/22 monthly spending min the community and Interview on 2/3/22 -She had never recistatement from the Interview between 2 stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the stated: -Quarterly accountiprovided to clients of the state of the stat	f client #3's record revealed: admitted 9/3/08. cophrenia-Paranoid Type, mental Disability-Mild, ce, Gastroesophageal Reflux Mellitus, Cholesterol n chest Lumps in Lung Area arterly accounting of client #3's ng provided to her guardian. ceipts 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 deposited monthly revealed: deposits of personal stimulus 021 for \$600.00 and April for social security deposits of 1/21 - 11/30/21. electronic benefits transfer veen 1/1/21 - 11/30/21 in the client #3 stated she received money, she regularly shopped nd she kept her money. client #2's guardian stated: eived a quarterly accounting facility. 2/2/22 - 2/4/22 the Licensee	V 542	In order to address on-going fin literacy of members for their per funds, the facility has developed form that gives members a choicauthorizing the representative provide financial management assistance of personal funds. Debra Barfield will monitor the situation on a monthly basis to that it does not happen again. The Facility's Board's Financial Community in the attached policy. Specified in the attached policy.	ersonal da ce of cayee nt ensure The mittee as	3/8/2022

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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MHL040030		B. WING		02/04	1/2022	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LUCILLE'S BEHAVIORAL, INC. #2)	OMAN ROA IBURG, NC				
PREFIX (EACH DEFICIENCY MUS	X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 542 Continued From page 6	6	V 542	V543		3/8/2022	
funds were deposited in	and any receipts. #2, and client #3's personal into a joint residential fund ients from sister facility A.		27F 0105 (d) Client Rights-Clien Personal Funds Based on record review and interviews, the facility failed to			
can be made from a per any amount owed or alled damages done or allege the client: (1) to the facility; (2) an employee of the client: (3) to a visitor of the facility of the client: This Rule is not met as Based on record review facility failed to receive facility failed to receive or legally responsible per was made from client's any amount owed or alled damages done by the company amount owed or alled the findings are: Finding #1 Review on 2/2/22 of client-43 year old female addromous properties of Schizoph Compulsive Disorder, Dintellectual Development	CLIENT'S PERSONAL e client or legally required before a deduction ersonal fund account for leged to be owed for red to have been done by of the facility; the facility; or ent of the facility. s evidenced by: w and interviews, the authorization by the client berson before a deduction s personal fund account for leged to be owed for client for 1 of 3 clients (#2). ent# 2's record revealed: mitted 11/21/17. hrenia, Obsessive Diabetes-Type A,	V 543	interviews, the facility failed to authorization by the client or le responsible person before a dec was made from client's personal account for any amount owed or alleged to be owed for damages by the client for 1 of 3 clients (#In order to alleviate or amelioral event from happening again. Lithave current members and/or the guardians to sign a form which acknowledges that they understand authorize the facility to dec from member's personal funds amount owed or alleged to be for damages done or alleged to been done by the client: (1) to facility. (2) an employee of the facility. (3) to a visitor of the facility. (4) to another client of the form to intake packet for new members well.	gally duction al fund or s done 2). te this BI will heir tand fuct any owed have the cility. facility.		

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	1 '0		COMPLETED		
	MHL040030		B. WING		R 02/04/2022			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
LUCILLE	LUCILLE'S BEHAVIORAL, INC. #2 351 HOLLOMAN ROAD							
LOCILLE		WALSTO	NBURG, NC					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING 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 543	Continued From pa	ge 7	V 543			3/8/2022		
	advocacy agency.							
	Review on 2/2/22 -	2/3/22 of facility bank						
		21 - 11/30/21 of a joint						
		ount where personal monies #1, client #3 and 2 clients from						
	sister facility A were	deposited monthly revealed:						
		deposits of personal stimulus 021 for \$600.00 and April 2021						
	for \$1400.00.	32 1 101 \$000.00 and April 2021						
	Review on 2/2/22 -	2/3/22 of an invoice dated						
	6/10/21 revealed:							
	 The invoice had the facility's address and was from a flooring company in a neighboring city. 							
	-"Description- Install roll goods (stock selection)							
	cost \$866.50Remove and dispose of existing							
	carpet/padding cost \$118.00prep floor and remove stapleses cost \$125.00, install thresholds							
	for (2) doors cost \$25.00Install primed quarter							
	round- quantity 120.00-cost \$2.00, total \$240.00." -The total bill was \$1374.00.							
	Interview on 2/3/22	client #2 stated: acility were cracked up ad the						
	whole house neede							
	-The floors had bee	en replaced throughout the						
	facility so it would "I	look nice." pay to replace the floors.						
		mes relieve herself in a trash						
		if someone else was in the						
	floor inside her clos	never relieved herself on the						
	noor maide her clos	oct.						
		client #2's guardian stated:						
	 She had been clief years inconsistently 	nt #2's guardian for about 2						
		client #2's incontinence issue.						
	1	contacted by anyone from the						
	facility to authorize	the use of client #2's personal						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R		
MHL040030		B. WING		02/0	4/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LUCILLI	E'S BEHAVIORAL, INC	· #2	OMAN ROA			
	CUBBBARDY OTA		IBURG, NC	PROVIDER'S PLAN OF CORRECTION	ONL	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETE DATE
V 543	Continued From pa	ge 8	V 543			
V 043	funds to pay for any caused by client #2-She would have evapproval for client pay for dan larges caused by case by case basis -In some cases clie used to pay for dan Interview on 2/3/22 stated: -The carpet in clien up because client # fecesThe carpet turned -Plyboard had to be and feces caused a Interview on 2/2/22 -Client #2 had a legadvocacy agencyClient #2 had receifor \$1400.00 that we residential fund accident #1, client #3 a A personal funds ar -Client #2 ruined he continuously urinatifloor having to be re-Client #2's \$1400.0 was used to pay for closet floor since client #2's inapprobeen discussed with with the local manalshe had not discus funds to pay for dar her bedroom closet -She had not received.	y damages at the facility y aluated the situation and and personal funds to pay for y clients is considered on a ent personal funds had been hages caused by them. the Group Home Manager t #2's closet had to be pulled to had soiled it with urine and brown. e installed because the urine a lingering smell. - 2/3/22 the Licensee stated: yal guardian with a local ived personal stimulus funds has deposited into the joint count where all of client #2, and 2 clients from sister facility for deposited. er bedroom closet floor by ing on it resulting in the closet	V 043			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
MHL040030		B. WING		R 02/04/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUCILLE	'S BEHAVIORAL, INC	* #7	LOMAN ROA NBURG, NC			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 543	Continued From pa	ige 9	V 543			
	pay for the replacer client #2's bedroom	ment of of the closet floor in				

Division of Health Service Regulation STATE FORM



FINANCIAL MANAGEMENT POLICY AND PROCEDURE

POLICY

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. If the facility assists a client with financial management the service will be provided accurately and according to these procedures to ensure the proper use of the client's funds.

PROCEDURE

- (a). Assistance with financial management is offered by this facility. Each client will have the choice to manage his or her own personal finances or to have the facility provide assistance, unless the client has a guardian who chooses to manage the finances, or is cognitively unable to manage his or her own finances. If the facility assists a client with financial management the service will be provided accurately and according to these policies and procedures to ensure the proper use of the client's funds.
- (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 these policy and procedures:
 - (1). The client shall be assured that the client, or representative payee has the right to deposit and withdraw money.

The facility will provide the client with a written notice that the client, or representative payee has the right to deposit and withdraw money.

(2). The facility will regulate the receipt and distribution of funds in a personal fund account.

The facility will deposit personal funds for the sole use of the client, and such funds will not be commingled with the funds of the facility or use for any purpose other than for the benefit of the client.

The facility will obtain a written receipt from the client for cash disbursement at the time of disbursement. The client will be required to initial or sign a completed receipt including the name of the client, the amount of the disbursement and the date of the disbursement.

The facility will keep a record of financial transactions with the client including the dates, amounts of deposits, amounts of withdrawals and the current balance. This includes deposits and withdrawals of any amount and purchases made by the provider on behalf of the client. Receipts will be kept for the purchases.

The facility will give the client and designated person an itemized account of financial transactions made on the client's behalf on a quarterly basis and a copy of whic will be kept in the client's record.

The facility will disburse the funds within 24 hours of the client request, during normal business hours.



The facility will provide the client the opportunity to review his or her financial record upon request during normal business hours.

(3). The facility will provide for the receipt of deposits made by friends, relatives or others.

The facility will receive funds, deposit funds, notify the client of the transaction, and disburse as requested by the client, all deposits made by friends, relatives or others.

(4). The facility will provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account.

The facility will keep a record of financial transactions with the client including the dates, amounts of deposits, amounts of withdrawals and the current balance. This includes deposits and withdrawals of any amount and purchases made by the provider on behalf of the client. Receipts must be kept for the purchases. The client will be required to sign a receipt for all cash disbursements to the client.

The facility will insure that at least annually, the personal fund account will be subject to review by the Finance Committee which will meet every 6 months and provide supporting financial documentation to the Quality Improvement Committee. The facilities' board of directors will review financial documentation for accuracy annually.

(5). The facility will keep a client's personal funds separate from any operating funds of the facility.

The facility will use the client's funds only for the client's benefit.

The facility will keep client funds separate from any operating funds of the facility.

(6). The facility will 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.

With written authorization, the facility will deduct 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.

(7). The facility will provide for the issuance of receipts to persons depositing or withdrawing funds.

The facility will issue and require issuance of receipts to and from all persons depositing or withdrawing funds.

(8). The facility will provide the client with a quarterly accounting of his personal fund account.

The facility will give the client and designated person an itemized account of financial transactions made on the client's behalf on a quarterly basis, a copy of which will be kept in the client's record.

(d). The facility will obtain written authorization from the client or legally responsible person before a deduction will be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client: (1) to the facility. (2) an employee of the facility. (3) to a visitor of the facility. or (4) to another client of the facility.