STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 survey was completed on 2/21/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC .5600C Supervised Living for Adults with Developmental Disability. The survey sample consisted of audits of 2 current clients.	V 000	The creation of this plan of correction constitutes a written proposal of compliance. This plan is prepared to demonstrate the good faith attempts by the provider to improve the quality of life of each resident, to respect the rights of each resident, and to ensure compliance with applicable state and federal requirements.	
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility whichserves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility whichserves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; 3) "C" designation means a facility which serves adults whose primary diagnosis is a	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 289	Continued From page 1 developmental disability but may also have other diagnoses; (4) "D" designation means a facility whichserves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility whichserves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in aprivate residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide care, habilitation or rehabilitation and supervision within the scope of	V 289	Licensee #1 and Licensee #2 will meet with QP and review the attendance policy requirement for 5600 C group homes to ensure that all staff members of HOL are fully aware of the attendance requirements. Licensees and staff are available for and appreciative of additional training opportunities to insure compliance. Licensee #1, Licensee #2 and QP will meet with client #1 and client #2 to go over the attendance requirements for 5600 C group homes to ensure that both clients and their families are aware of the required attendance policy for 5600 C group homes. Licensee #1 and Licensee #2 will ensure that client #1 and client #2 comply with the residential requirements, that they are present daily to complete any goals listed on their treatment plan, and provide any and all support that is needed to reach these goals. Licensee #1 and Licensee #2 will report any absences or attendance changes that may occur with Client 1 and Client 2 to the assigned DSS worker. Licensee #1 and #2 have attempted to comply with, and will ensure compliance with the following to encourage family participation:	

			10A NCAC 27G .5603 OPERATIONS (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Licensee #1 and Licensee #2 submit that all actions taken by the facility were done with the full knowledge and consent of the legally responsible person of the adult resident and were done in the best interest of the adult resident. No action on part of either licensee was intended to cause, nor caused any harm, neglect or exploitation to the resident as defined in G.S. 122C-66	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 289	Continued From page 2 residential services affecting 2 of 2 clients (clients #1 and #2). The findings are: Interview on 2/15/22 with the Licensee #1 revealed: -She had 2 clients, but they were both out of the facility; -Client #1 was spending time with his mom because she had been diagnosed with cancer; -She couldn't remember when client #1 left the facility and wasn't sure when he was going to return; -Client #2 had been staying with his mom since the Licensee #1's mother passed away on 12/3/21 and she needed time to grieve; -Client #2 was scheduled to return to the facility on 2/21/22. Reviews on 2/16/21 - 2/18/21 of client #1's record revealed: -An admission date of 9/15/18; -Diagnoses included Infantile Cerebral Palsy, Major Depressive Disorder and Obsessive-Compulsive Disorder; -A medication administration record (MAR) for the month of March 2020 with handwritten notes by the Licensee #1 on the back which read: "3-13-20 Client went home at 9:15 am. Meds (Medications) given to take home. 3-31-20 Client still home due to Corona Virus;" -MARs for the months of April 2020 - February 2022 with handwritten notes by the Licensee #1 on the back which read: "Client home due to Corona Virus. Meds taken to client;" -A treatment plan dated 12/2/20 included goals of, "... would like to live a healthy lifestyle and will receive support on how to make better food choices and watch my consumption of junk foods, in order to keep my weight in check...would like to learn new social and communication skills so I	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 289	Continued From page 3 can be more social and meet new people...would like to improve my routinely daily living skills;" -A Treatment Plan update on 3/3/21 included, "Staff will continue to support [Client #1] during times when he is frustrated and continue to advise him in his food choices with no more than 4 VP's (verbal prompts) per month. [Client #1's] family have discussed there are times when [Client #1] does not communicate his feelings to them and his behavior has sometimes not been in a positive manner. Staff will continue to work with [Client #1] and give him support to ease his frustrations and to assure that normalcy will be back and he needs to show positive behavior. Staff will continue to monitor [Client #1] with no more than 4 VP's per month on his daily routines;" -A Treatment Plan update on 6/1/21 included, "Staff will continue to give [Client #1] support and guidance with no more than 4 VP's per month. [Client #1's] behavior has changed and his family has had conversations with staff regarding [Client #1's] behavior. Since, [Client #1's] activities have changed due to the virus and this plays a major role in his current lifestyle, staff take [Client #1] to parks and out to lunch away from other individuals or crowds. Staff will continue to provide support and discuss topics that [Client #1] seems pleased and relaxed. Eye contact will be monitored as well with no more than 4 VP's. [Client #1's] daily living skills have not improved and this is another discussion between staff and his family. Staff will continue to support [Client #1] and provide feedback with no more than 4 VP's per month;" -A Treatment Plan update on 9/1/21 included, "Staff has taken [Client #1] to outside outings and this helps his anxiety as well as his frustrations. Staff will continue to monitor [Client #1] and work on his social/communication skills as well as eye	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 289	Continued From page 4 contact with no more than 4 VP's. [Client #1's] family has reported, [Client #1] has often been told or sent back in the bathroom to clean himself up again;" -A treatment plan dated 12/3/21 that included goals of, "... want to live a healthy lifestyle and receive support on how to make better food choices...would like to learn new social and communication skills so I can be more social and meet new people...I would like to improve my routinely daily living skills." Reviews on 2/16/21 and 2/17/21 of client #2's record revealed: -An admission date of 3/30/19; -Diagnoses included Autism Spectrum Disorder, Borderline Intellectual Functioning, Generalized Seizure Disorder, and Schizoaffective Disorder; -MARs for the months of November 2021 - February 2022 indicate that the last time medication was administered by facility staff was 11/23/21 and the days since then contained a H indicating that the client was on a home visit; -A treatment plan dated 3/22/21 that included goals of, "[Client #2] will be able to increase his level of socialization and communication skills as evidenced by: Attending [a day program] 5x (times) a week for increased socialization skills...will independently communicate his wants and needs to increase his social and communication skills with no more than 4 VP's...will independently say Yes or No, or Please when been asked or offered something...will be given prompts and reminders when he is been repetitive when communicating with no more than 4 VP's...[Client #2] will recognize his medications independently when they are given to him by staff daily for 3 consecutive months." Interview on 2/16/21 with the Licensee #1	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 289	Continued From page 5 revealed: -She visited with client #1 at his mother's home at least weekly, delivered his medications monthly and sometimes took him on outings; -She talked with client #2 on the telephone at least weekly while he had been at his mother's; -Both of the clients' families were assisting with the goals on the treatment plan and they contacted her if they had questions or concerns; -The Qualified Professional spoke via Zoom or telephone with both clients at least a couple of times a month. 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.	V 289	Licensee #1 and Licensee #2 will ensure that all clients, both present and future, are in attendance daily at HOL to ensure that the clients are receiving all medications and their treatment plans are being implemented. HOL will respect the client's rights to visit their families. If clients make the decision to do long term visits, then HOL will continue to document those visits but will also report these absences to the necessary officials. Licensee #1, Licensee #2 and QP will ensure that while clients are on any short term visit with their families, that they receive all daily medication and any support that is needed to complete their goals listed in their treatment plans.	
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to anysort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold toor purchased from a client except through established governing body policy. (d) Employees shall use only that degree offorce 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	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 6 intervention procedures shall be compliance with 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. This Rule is not met as evidenced by: Based on record reviews and interviews, 2 of 2 Licensees (#1 and #2) exploited and neglected 2 of 2 clients (#1 and #2). The findings are: Cross Reference: 10A NCAC 27G .5601 Scope (V289) Based on record review and interviews, the facility failed to provide care, habilitation or rehabilitation and supervision within the scope of residential services affecting 2 of 2 clients (clients #1 and #2). Interview on 2/15/22 with client #1's family caretaker revealed: -She was the caretaker for client #1 and his mother as she had been diagnosed with cancer 4 years previously and was receiving treatment; -She was unsure how long client #1 had been out of the facility because she had not been the caretaker the entire time but knew it had been at least 4-5 months; -The Licensee #1 visited with client #1 weekly and was being understanding about holding his bed. Interview on 2/15/22 with client #2's family caretaker revealed: -Client #2 had been on a home visit when the Licensee #1's mother passed away in December 2021; -She had offered to keep client #2 in order to give the Licensee #1 time to grieve;	V 512	Due to the Covid Pandemic, client #1 and his family made the decision to adhere to the CDC guidelines for the covid pandemic. Client #1 made the decision to long term visit with his mother to prevent any exposure to covid and to ensure that he would not bring any symptoms of covid into his mothers' home during his routine visits. Any exposure to covid would have been medically severe to his mother who is currently suffering from a terminal illness. Client #1 and his family requested that HOL hold his room till the CDC lifted the pandemic guidelines and client #1 and his family felt comfortable with him returning full time to HOL while going back to his normal visits with his family. Regarding the Covid pandemic, or any health pandemic, Licensee #1 and Licensee #2 will meet with the QP and develop a policy procedure plan that will address any present and future client's ability to visit family for long term reasons during health pandemics. Licensee #1 and Licensee #2 will ensure that there is available staff to provide support to any clients both present and future, to provide coverage during life changing events that may occur involving the HOL family and staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 7 -Client #2 was going to return to the facility, "this weekend because he's got some appointments (medical) next week." Interviews on 2/16/22 and 2/18/22 with the Qualified Professional revealed: -She had worked at the facility for 2 years; -Client #1 had left the facility to stay with his mother when the Corona Virus was announced; -Client #2 had left the facility to stay with his mother when the Licensee's mother passed away in December 2021; -She communicated via Zoom or telephone twice a month with clients #1 and #2. Interview on 2/16/22 with the Licensee #2 revealed: -He had worked as a Paraprofessional at the facility since it was licensed in 2018; -There were currently no clients at the facility but when there were clients, he worked daytime on the weekends; -None of the family had previous experience regarding facilities prior to becoming licensed. Interviews on 2/17/22 with a Supervisor at a county Department of Social Services (DSS) revealed: -They were not aware that client #1 had been out of the facility since 3/13/20; -When clients were out of the facility more than 10 consecutive days, it was required to be reported to DSS; -A Special Assistance review was completed on 3/23/21 and Licensee #1 "verified resident status;" -Licensee #1 was not eligible to receive room and board for client #1 while he was out of the facility; -The amounts paid to the Licensee #1 included 3/2020 - 12/2020 $205 monthly, 1/2021 - 11/2021	V 512	Client #2 made the decision to visit his mother for the Thanksgiving holiday. While client #2 was visiting his mother, several deaths occurred in his family. Due to this, client #2 mother decided to keep him with her to give him them the opportunity to grieve the loses in their family. Licensee #1 often contacted mother asking when the client would return to HOL.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

(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 8 $175 monthly, 12/2021 $188 monthly, and 1/2022 - 2/2022 $122 monthly which totaled $4,407 and will have to be paid back; - The Licensee #1 also received room and board for client #2 while he was out of the facility from 11/23/21 - current (2/17/22); -The amount the Licensee #1 received was not available because payments were paid from a different county but would also have to be paid back. Interview on 2/21/22 with an Income Maintenance Caseworker at a different county DSS revealed: -The Licensee #1 received $407 per month for room and board for client #2; -If the client did not reside at the facility, Licensee #1 was not eligible for any of January 2022 and possibly only partial months for December 2021 and February 2022. Interview on 2/18/22 with a representative from the Social Security Administration (SSA) revealed: -The Licensee #2 applied in May 2020 to be client #1's representative payee as an individual and not on behalf of the facility; - The Licensee #2 received $790 per month for client #1; -Client #1's social security check was suspended immediately (2/18/22) pending a fraud investigation; -The total pay back amount for client #1 totaled more than $16,000; -The facility was payee for client #2 and had received monthly payments of $841; -The monthly amounts for December 2021 January 2022 and possibly February 2022, would need to be returned to the SSA and they would determine where the money should have been sent.	V 512	Licensee #1 and Licensee #2 has currently addressed any concerns for payments received on behalf of client #1 and client #2 in regard to the time said clients was not present at HOL with the Social Security Administration. Licensee #1 and Licensee #2 will address any future concerns for this matter with the Social Security Administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

(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 9 Interviews on 2/17/22 and 2/21/22 with the Licensee #1 revealed: -She didn't understand why she was not eligible to receive client #1 and #2's social security and room and board monthly when they were out of the facility; -She wasn't billing for services monthly and only keeping what she received monthly from SA and Social Security to hold the beds for the clients; -She had no records of the monies she received since it was all direct deposited; -"If I ask his (client #1's) mama and she tell me frequently he can't come back yet, what am I supposed to do;" -"In my policy it say if they (clients) live in my home (facility) they have to go to a day program and he (client #1) can't go to a day program;" -"If his mama say she don't want him back in there (day program) because she wants to live, she has that right;" -"Y'all can't make me change my policy...y'all have to abide by my policy;" -"Due to Corona Virus, if the Corona Virus wasn't here, [client #1] would be here (at the facility) with me;" -"Other business made other leniency for others, why can't [client #1];" -"[Client #1] lost his step-dad, his cat and he's losing his mama and if you tell him he's losing his home here, that's suicide and I'll be the first on the news to tell everyone it's because of DSS and DHHS (Department of Health and Human Services);" -"I don't like the word fraud...I was not aware that after 10 days a report (regarding SA and Social Security) should have been made...fraud is fraud regardless, but I didn't know...He (client #1) doesn't lay down here (the facility), but I do everything else for him;"	V 512	Licensee #1 and Licensee #2 will ensure that all HOL staff adhere to the state guidelines and the policy procedures listed in the HOL manual. Licensee #1 and Licensee #2 will continue to be mindful that they are advocates for the clients residing in HOL. Licensee #1 and Licensee #2 will continue to advocate, respect, monitor and support the client's ability to make choices for themselves.	

(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 10 -She had not asked client #2's mother to keep him out of the facility but the mother had offered; -"I called Raleigh last year and asked when y'all were going to come out and do an inspection...If y'all had come out in March like you were supposed to, none of this would have happened...y'all kicked the wrong dog;" - The Licensee #2 was her son and both of her sons were Facility Co-Owners; -Her husband had no involvement in the facility and she wasn't sure why the 2022 License Renewal Application that she completed on 12/12/21 included her husband as a Co-Owner. Attempted additional interview on 2/18/22 with the Licensee #2 was not successful as he did not return calls. Attempted interviews on 2/15/22 and 2/18/22 with the Facility Co-Owners #1 and #2 were not successful as they did not return calls. Interview on 2/18/22 with the Licensee #1 revealed: -Her husband (Facility Co-Owner) was not involved with the facility; -She wasn't sure why the License application that she completed on 12/12/21 included her husband as a Co-owner; -Only her 2 sons were a part of the facility and were co-owners; -She and her sons had talked with client #1's father who was an attorney and he had advised her sons to not speak with anyone regarding the survey. Reviews on 2/17/22 and 2/21/22 of the Plan of Protection completed and dated 2/17/22 and updated 2/21/22 by the Licensee #1 revealed: "What immediate action will the facility take to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 11 ensure the safety of the consumers in your care? More training in the area that I am I supposed to be aware of to report such incidents like this. I was not aware that after 10 days, reports should have be made. I was told to contact the right individuals to report when client is out of the home, more than 10 days. Describe your plans to make sure the above happens. On February 17, 2022, I call Medicaid to get a clear understanding of how long clients can be away from the home. I was told TODAY 10 DAYS. I will call SSA to report/explain this mishap as well on 2-17-22. 2-21-22 I was told another citing was added and still unclear what provider is been cited for. At first we were told Fraudulent, later it was told we were changed 2 violations stated above. When clients are at facility, they were not neglected, abuse and clients should have the right to spend time with family during sickness/deaths. The staff of HOL (House of LUV) continued to monitor clients when they were away from facility. House of LUV have requested APPEALS 2 times! We are requesting Appeal Again. This is the 3rd time." This facility is licensed to provide supervised living to 3 adults with a developmental disability. The facility was serving 2 clients with diagnoses that included Autism Spectrum Disorder, Infantile Cerebral Palsy, Generalized Seizure Disorder, Schizoaffective Disorder, Major Depressive Disorder, and Obsessive-Compulsive Disorder. Client #1 had not spent the night at the facility since 3/13/20 and there was no set date for him to return to the facility. Client #2 had not spent the night at the facility since 11/23/21 and was scheduled to return to the facility on 2/21/22. The Licensees #1 and #2 had been receiving SA and Social Security for both clients while they were out of the facility. According to the Licensee #1,	V 512	Licensee #1 and Licensee #2 will request the that Department of Health and the Department of Social Services give the necessary training to them and the staff at HOL to ensure that there is a clear understanding of the guidelines and general statues that govern the 5600C group homes settings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-376	A. BUILDING: _____ B. WING _____	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LUV	3203 MEADOW LANE WINSTON SALEM, NC 27107

(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 the money that they received was to ensure the clients beds were held until they returned to the facility. The families of clients #1 and #2 were aware that the Licensees #1 and #2 were receiving SA and Social Security for the clients in order to hold the clients' beds. The Licensee #1 informed the clients' families that she was unable to hold their beds without payment even though there was at least 1 vacant bed since the facility was originally licensed on 3/2/18. The Licensees #1 and #2 financially exploited clients #1 and #2 for a total that equals over $22,000 during the previous 23 months of March 2020 - February 2022. The Licensees #1 and #2 seriously neglected clients #1 and #2 as they failed to provide residential services including supervision, medication administration and services on the Treatment Plan while getting paid for the services. This deficiency constitutes a Type A1 rule violation for serious exploitation and neglect 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		

THE HOUSE OF L.U.V. (Life Is Unique & Valuable), LLC
MHL #034-376

March 25, 2022

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

Attn: Ms. Robin Sulfridge
Western Mental Health Branch Manager

RE: Plan of Correction
3203 Meadow Lane
Winston-Salem, NC 27107

The Division of Health Service Regulation (DHSR) conducted an annual survey and it was completed on 2/21/22.

I have completed and enclosed a Plan of Correction for HOL, LLC as it relates to our facility located at 3203 Meadow Lane, W-S, NC 27107.

On behalf of HOL, No action on part of either licensee was intended to cause, nor caused any harm, neglect or exploitation to the residents, as defined in
G.S. 122C-66.

Client #1 and his family requested the House of L.U.V. to hold Client #1 room. All actions taken by the facility were done with full knowledge and consent of the legally responsible person of the adult resident and his family, and were done in the best interest of the adult resident.

If you have any questions, you can contact Johnnie S. Brown at (336) 480-5115.

Sincerely,

Johnnie S. Brown
Administrator
House of L.U.V. (Life is Unique & Valuable), LLC

"And now these three remain: faith, hope and love. But the greatest of these is love."
1 Corinthians 13:13