	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	BERTH IONTION NOMBER.				
		MHL078-150				R-C / <b>12/2023</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
HOPE HO	DUSE		D LOWERY RO N, NC 28386	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	on January 12, 202 substantiated (intak Deficiencies were c This facility is licens	ited. sed for the following service C 27G .1700 Residential				
		sed for 4 and currently has a urvey sample consisted of clients.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved b authority. (b) The plan shall b and evacuation pro posted in the facility (c) Fire and disaste shall be held at lease repeated for each s under conditions th	207 EMERGENCY PLANS in for each facility and plan shall be developed and by the appropriate local e made available to all staff cedures and routes shall be /. r drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies				
	failed to ensure fire	et as evidenced by: view and interviews the facility and disaster drills were held ted on each shift. The findings				

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		MHL078-150	B. WING			R-C 01/12/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
HOPE HO	OUSE		D LOWERY RC DN, NC 28386	DAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 114	Continued From pa	ge 1	V 114				
	Review on 1/11/23 of the facility's records of fire and disaster drills from July 2022 - December 2022 revealed: -No fire drills were documented for the 8pm - 8am shift from July 2022 - December 2022. -No disaster drills were documented for the 8am - 8pm or 8pm - 8am shifts from July 2022 - December 2022.						
	stated: -The shifts for the fa 8pm - 8am. -Fire and disaster d month. -She was sure disa she was unable to l	3 the Associate Professional acility were 8am - 8pm and Irills were completed twice a ster drills were completed but ocate them. drills were completed.					
	-She knew the facil drills.	3 the Program Director stated: ity completed fire and disaster ow often drills were completed					
	This deficiency con and must be correc	stitutes a re-cited deficiency ted within 30 days.					
V 121	27G .0209 (F) Med	ication Requirements	V 121				
	governing body or of for obtaining a revie regimen at least ev						

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		MHL078-150	B. WING		R-C 01/12/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	1 •	
HOPE H	OUSE		D LOWERY RO	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 121	Continued From pa	ige 2	V 121			
	the client's physicia the review when m (2) The findings of	site manager shall assure that in is informed of the results of edical intervention is indicated. the drug regimen review shall client record along with applicable.				
	facility failed to obta of 2 audited clients	et as evidenced by: views and interviews the ain drug regimen reviews for 2 (#2 and #3) who received ations. The findings are:				
	-13 year old male. -Admitted on 6/6/22 -Diagnoses of Disru Disorder, Post trau	of client #2's record revealed: 2. uptive Mood Dysregulation matic Stress Disorder chronic, it Hyperactive Disorder				
	(ADHD) combined -Signed and dated psychotropic medic -Aripiprazole 10 -Vyvanse 70 m -Trazodone 100	type. physician's orders for cations: 0 milligram (mg) daily. g daily. 0 mg as needed.				
	-Guanfacine 1 -No documented dr	ng at bedtime. rug regimen review.				
	-15 year old male. -Admitted on 7/11/2 -Diagnoses of ADH	D combined, Oppositional d Unspecified trauma and				
ision of L		physician's orders for				

If continuation sheet 3 of 17

STATEME	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		MHL078-150	B. WING			R-C 01/12/2023	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
			D LOWERY RO				
HOPE H	003E	SHANNO	N, NC 28386				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 121	Continued From pa	ge 3	V 121				
	-Focalin XR 25 -Guanfacine 2 i -Quetiapine 25 -No documented dr	- mg daily. mg twice daily. mg at bedtime.					
	Director stated: -The facility recently used.	3 - 1/12/23 the Program y switched the pharmacy they g regimen reviews completed					
	C C	stitutes a re-cited deficiency					
V 293	<ul> <li>10A NCAC 27G .17</li> <li>(a) A residential trechildren or adolescent free-standing resider intensive, active the interventions within shall not be the print who is not a client of (b) Staff secure means awake during client shall be continuous this Section.</li> <li>(c) The population adolescents who has mental illness, emons substance-related of co-occurring disord disabilities. These not meet criteria for (d) The children or require the following the source of th</li></ul>	eatment staff secure facility for ents is one that is a ential facility that provides erapeutic treatment and a system of care approach. It nary residence of an individual of the facility. eans staff are required to be sleep hours and supervision as set forth in Rule .1704 of served shall be children or ave a primary diagnosis of tional disturbance or disorders; and may also have ers including developmental children or adolescents shall inpatient psychiatric services. adolescents served shall					

Division of Health Service Regulation STATE FORM

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HOPE HOUSE 3775 OLD LOWERY ROAD SHANNON, NC 28386 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
MHL078-150     Is. WING     Other       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, JP CODE       MOPE HOUSE     STREET ADDRESS, CITY, STATE, JP CODE       MAIL OF ALL     STREET ADDRESS, CITY, STATE, JP CODE       MAIL OF ALL     SUMMARY STATEMENT OF DEFICIENCIES.     D       PRETX     REGULTION OR USC DENTIFYING INFORMATION     D     PRECVENT       V293     Continued From page 4     V 293     V 293     DEFICIENCIES.       (2)     treatment in a staff secure setting.     Conserver ender of control behaviors related to:     DEFICIENCIES.       (3)     envices hall be designed to:     (1)     minimize the occurrence of behaviors related to functional deficits;       (3)     envices hall be designed to:     (1)     assist the child or adolescent in the acquisition of adolescent in the acquisition of adolescent in the acquisition of adolescent in gaining the skills needed to step-down to a less intensive freatment setting.     (1)       (1)     the residential setting in self-control, communicate with other individuals and agencies within the child or adolescent's system of care.     This Rule is not met as evidenced by:       Based on record review and interviews the facility failed to ensure safety and cocordinate with other individuals and agencies within the client's system of care.     This Rule is not met as evidenced by:	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
TATE DLD LOWERY RDAD BHANNON, NC 2838           OWNER PREFIX         SUMMARY STATEMENT OF DEFICIENCE WILL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY)         D PREFIX         PPOWDER'S PLAN OF CORRECTION (COSSAREFERENCED TO THE APROPRIATE         O OC           V233         Continued From page 4         V233         V233         V233         V233           (B) Services shall be designed to: (B) Services shall be designed to: (C) entrol be designed to: (C) entrol deficits: (C) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (C) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (C) support the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (C) support the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and of care.         I his Rule is in ot met as evidenced by: Baed on record review and interviews the facility shall coordinate with other individuals and again genes.         I his Rule is in ot met as evidenced by: Baed on record review and interviews the facility failed to ensure safety and goordinate with other individuals and agenesies within the clients' system of care or 102 audited clients. The findings are:         I his Rule is in ot met as evidenced by: Baed on record review and interviews the facility failed to ensure safety and coordinate with other individuals and ageneies within the clients' system of care for 102 audited clients.			MHL078-150	B. WING		R-C 01/12/2023	
HOPE HOUSE         SHANNON, NC 28386           (24) ID PREYX TAG         SUMMARY STATEMENT OF DEFICIENCES RESULTIONY OR LSC IDENTIFYING INFORMATION)         ID PREYX TAG         PROVIDENS PLAN OF CORRECTION ACTION BAULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY         Continued From page 4         V 293           V233         Continued From page 4         V 293         V 293           community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (a) ensure safety and deescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.           This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure safety and coordinate with other individuals and agencies within the clients' system of care for 1 of 2 audited clients. The findings are:	NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
Main Drag     SUMMARY STATEMENT OF DEFICIENCIES     Drag     Drag     PRAVIDES 2000     PRAVIDES 20000     PRAVIDES 20000     PRAVIDES 20000     PRAVIDES 20000     PR	HOPE HO	DUSE			DAD		
Préférix TAG       (EACH CORRECTIVE ACTION SHOULD BE RECULATORY OR LIS DENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DO THE APPROPRIATE       000         V233       Continued From page 4       V233       V233       DEFICIENCY)       V233         V243       Continued From page 4       V233       V233       DEFICIENCY)       DEFICIENCY)       DEFICIENCY)         V235       Continued From page 4       V233       V233       DEFICIENCY)       DEFICIENCY       DEFICIENCY)       DEFICIENCY       <				N, NC 28386			
community-based residential setting in order to facilitate treatment; and         (2)       treatment in a staff secure setting.         (e)       Services shall be designed to:         (1)       include individualized supervision and structure of daily living;         (2)       minimize the occurrence of behaviors related to functional deficits;         (3)       ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;         (4)       assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and         (5)       support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.         (f)       The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.         This Rule is not met as evidenced by:       Based on record review and interviews the facility failed to ensure safety and coordinate with other individuals and agencies within the clients' system of care for 1 of 2 audited clients. The findings are:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
<ul> <li>facilitate treatment; and</li> <li>(2) treatment in a staff secure setting.</li> <li>(e) Services shall be designed to:</li> <li>(1) include individualized supervision and structure of daily living;</li> <li>(2) minimize the occurrence of behaviors related to functional deficits;</li> <li>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</li> <li>(4) assist the child or adolescent in the acquisition of adaptive functional and recreational skills; and</li> <li>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</li> <li>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</li> </ul>	V 293	Continued From pa	ige 4	V 293			
findings are:		facilitate treatment; (2) treatment (e) Services shall to (1) include in structure of daily liv (2) minimize related to functiona (3) ensure sa control behaviors in management with of (4) assist the acquisition of adapt communication, so (5) support th gaining the skills ne intensive treatment (f) The residential to shall coordinate wit agencies within the of care.	and in a staff secure setting. be designed to: dividualized supervision and ring; the occurrence of behaviors I deficits; afety and deescalate out of neluding frequent crisis or without physical restraint; child or adolescent in the tive functioning in self-control, cial and recreational skills; and he child or adolescent in seded to step-down to a less setting. treatment staff secure facility th other individuals and child or adolescent's system				
		system of care for findings are: Review on 1/11/23	1 of 2 audited clients. The				
-15 year old male. ision of Health Service Regulation	ision of He						

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		MHL078-150	B. WING	B. WING		R-C <b>12/2023</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HOPE H	DUSE		D LOWERY RO N, NC 28386	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 293	Defiant Disorder an stressor related dis Record on 1/12/23 Sheet" for client #3 -"Date: 1-5-23" -"Time: 2:30 p.m. -"Group Home Con a syncope episode the emergency rool 8-hour waiting perio person, place, time scheduled for an er determine the poss reported feeling we -"Care Provider Tree would not treat [Clie his lab work and hin Provider recommer at the Emergency F Interview on 1/11/2 Professional stated -Client #3 fainted at transported to the le by ambulance. -The Program Direct ER. -The ER completed	22. D combined, Oppositional ad Unspecified trauma and order. of a facility's "Appointment revealed: accerns: The client experienced yesterday and was taken to m however; there was an od. The client was oriented to and situation. The client was mergency appointment to bible reason for syncope. Client ak and tired." eatment/Finding: Provider ent #3] due to the results from m having a fever of 103. nded that [Client #3] be treated Room to start IV antibiotics." 3 - 1/12/23 the Associate				
	8 hour wait. -She followed up w provider the followin -Client #3's primary comfortable treating labs from the ER and seen at the ER the	ith client #3's primary care ng day and he was seen. v care provider did not feel g client #3 after reviewing his nd stated he needed to be				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
		MHL078-150	B. WING		R-C 01/12/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
HOPE HO	DUSE		D LOWERY RO N, NC 28386	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 293	Continued From pa	ge 6	V 293			
	a long wait at the El -Client #3 was diag infection and was d morning. Interview on 1/11/23 Director stated: -She went to the EF -The ER only comp -Client #3 was trans sent to the ER lobby -The ER announced be seen. -The ER did not ma what patients shoul -She made the deci client #3 before he -Client #3 had a his the same symptoms -She thought it wou by his primary care -She did not consid	nosed with a urinary tract ischarged the following 3 - 1/12/23 the Program R with client #3. leted labs on client #3. sported by ambulance but was y to wait. d there was an 8 hour wait to lke an recommendations on d do. ision to leave the ER with was seen by a doctor. tory of dehydration and had s. Id be easier to have him seen provider. er client #3's need to be seen				
V 364	the lobby.	ecause the ER placed in him litional Rights in 24 Hour	V 364			
	<ul> <li>§ 122C-62. Addition</li> <li>Facilities.</li> <li>(a) In addition to the 122C-51 through G who is receiving tree 24-hour facility keep (1) Send and received access to writing matches assistance when negative statements.</li> </ul>	ve sealed mail and have aterial, postage, and staff				

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL078-150	B. WING		R-C 01/12/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
HOPE H	DUSE		LOWERY R N, NC 28386		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	
V 364	Continued From pa	ge 7	V 364		
	physicians, and priv developmental disa professionals of his (3) Contact and co there is a client adv The rights specified restricted by the face exercise these right (b) Except as provi of this section, each treatment or habilitat times keeps the right (1) Make and receiv calls. All long distant the client at the time collect to the receiv (2) Receive visitors a.m. and 9:00 p.m. hours daily, two hou p.m.; however visition over therapies; (3) Communicate as supervision with ind upon the consent of (4) Make visits outs unless: a. Commitment pr the result of the cliev violent crime, includo assault with a dead respondent was four insanity or incapable b. The client was four insanity or incapable	bilities, or substance abuse choice; and nsult with a client advocate if ocate. I in this subsection may not be cility and each adult client may is at all reasonable times. Ided in subsections (e) and (h) n adult client who is receiving ation in a 24-hour facility at all ht to: ive confidential telephone nee calls shall be paid for by e of making the call or made ing party; s between the hours of 8:00 for a period of at least six urs of which shall be after 6:00 ng shall not take precedence and meet under appropriate lividuals of his own choice f the individuals; side the custody of the facility roceedings were initiated as ent's being charged with a ding a crime involving an ly weapon, and the and not guilty by reason of			

Division	of Health Service Re	equiation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL078-150	B. WING		R-C 01/12/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOPE H	OUSE		LOWERY R N, NC 28386			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 364	Continued From page 8		V 364			
	otherwise prohibited conditions prescribe (5) Be out of doors facilities and equipr several times a wee (6) Except as prohi- personal clothing and client is being held proceed pursuant to (7) Participate in ref (8) Keep and spen own money; (9) Retain a driver's prohibited by Chapt and (10)Have access to his private use. (c) In addition to th 122C-51 through G 122C-59 through G who is receiving tre 24-hour facility has proper adult superv recognition of the m- individual, the mino- opportunities to ena- emotionally, intellect vocationally. In view and intellectual imm 24-hour facility shall structure, supervision the rights given to the The facility shall als reasonable efforts to client receives treat	expressly authorize visits d by the existence of the ed by this subdivision; daily and have access to ment for physical exercise ek; ibited by law, keep and use nd possessions, unless the to determine capacity to o G.S. 15A-1002; eligious worship; d a reasonable sum of his is license, unless otherwise er 20 of the General Statutes; individual storage space for e rights enumerated in G.S. S. 122C-57 and G.S. S. 122C-61, each minor client atment or habilitation in a the right to have access to ision and guidance. In minor's status as a developing r shall be provided able him to mature physically, etually, socially, and v of the physical, emotional, naturity of the minor, the I provide appropriate on and control consistent with the minor pursuant to this Part. o, where practical, make o ensure that each minor ment apart and separate from the treatment needs of the				

Division	of Health Service Re	equiation			FURIM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL078-150	B. WING		R-C 01/12/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HOPE H	OUSE		LOWERY R N, NC 28386	DAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	ΓΙΟΝ	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
V 364	Continued From pa	ge 9	V 364			
	<ul> <li>habilitation from a 2</li> <li>(1) Communicate a guardian or the age custody of him;</li> <li>(2) Contact and co or that of his legally cost to the facility, le physicians, private a disabilities, or subst his or his legally res (3) Contact and co there is a client adv The rights specified restricted by the fac may exercise these (d) Except as provio of this section, each treatment or habilitat the right to:</li> <li>(1) Make and receid distance calls shall time of making the receiving party;</li> <li>(2) Send and receid writing materials, powhen necessary;</li> <li>(3) Under appropriation visitors between the p.m. for a period of hours of which shall visiting shall not tak therapies;</li> <li>(4) Receive special training in accordance</li> </ul>	I in this subsection may not be bility and each minor client rights at all reasonable times. ded in subsections (e) and (h) minor client who is receiving ation in a 24-hour facility has twe telephone calls. All long be paid for by the client at the call or made collect to the we mail and have access to ostage, and staff assistance ate supervision, receive the hours of 8:00 a.m. and 9:00 at least six hours daily, two I be after 6:00 p.m.; however the precedence over school or I education and vocational foce with federal and State law; daily and participate in play, sical exercise on a regular				

Division	of Health Service Re	egulation				APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL078-150	B. WING		R-C 01/12/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		3775 OLD	LOWERY RO	DAD		
HOPE H	OUSE	SHANNO	N, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 364	Continued From page 10		V 364			
	appropriate supervi held to determine c G.S. 15A-1002; (7) Participate in re (8) Have access to the safekeeping of (9) Have access to of his own money; a (10)Retain a driver's prohibited by Chapt (e) No right enume of this section may by the qualified prof formulation of the c plan. A written state client's record that i for the restriction. T reasonable and rela habilitation needs. A period not to excee each restriction sha qualified profession at which time the re Each evaluation of documented in the rights may be renew statement entered b the client's record th renewal of the restriction of rig by the client shall, u be notified of the re it. In the case of a n adult client, the lega be notified of each	individual storage space for personal belongings; and spend a reasonable sum				

If continuation sheet 11 of 17

	of Health Service Re			CONSTRUCTION		
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
MHL078-150		MHL078-150	B. WING			-C 1 <b>2/2023</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HOPE H	OUSE		LOWERY RC N, NC 28386	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From pa	ige 11	V 364			
	individual or legally	cation of the designated responsible person shall be ing in the client's record.				
	This Rule is not met as evidenced by: Based on record reviews and interviews the facility restricted the rights of 2 of 2 audited clients (#2 and #3) by restricting their ability to make and receive telephone calls. The findings are:					
	-13 year old male. -Admitted on 6/6/22 -Diagnoses of Disru Disorder, Post trau and Attention Defici (ADHD) combined	uptive Mood Dysregulation matic Stress Disorder chronic, it Hyperactive Disorder type. for authorization for restriction				
	-Clients could use t his mom suggested Thursdays.	3 client #2 stated: use the phone once a week. the phone 3 times a week but d he only called her on with them during their phone				
ision of U	-15 year old male. -Admitted on 7/11/2 -Diagnoses of ADH	D combined, Oppositional d Unspecified trauma and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		MHL078-150	B. WING			R-C 01/12/2023	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
IOPE HO	DUSE		LOWERY RC	DAD			
			N, NC 28386			(1.1-)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 364	Continued From page 12		V 364				
	<ul> <li>-No documentation for authorization for restriction to make and receive calls.</li> <li>Interview on 1/11/23 client #3 stated:</li> <li>-Client were allowed to make calls on Thursday, Friday and Sunday.</li> <li>-Clients were not allowed to have privacy during calls and a staff was always present.</li> </ul>						
	stated: -The clients were al Thursday's, Friday's -The clients were al and each client reco -The calls were limit answered the client -The phone schedur during the intake pr	lowed to make calls at 7pm eived 15 minutes. ted to 1 receiving caller who s call. le was explained to guardians ocess. during the clients calls due to					
	-The facility had a p -The clients had act week and the days schedule. -The phone policy v process and review	cess to the phone 3 days a were based on the facility's vas a part of the intake ed with the guardians. locate the phone policy in					
	This deficiency con and must be correc	stitutes a re-cited deficiency ted within 30 days.					
V 513	27E .0101 Client Ri Alternative	ghts - Least Restictive	V 513				
	10A NCAC 27E .01	01 LEAST RESTRICTIVE					

Division of Health Service F STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FEAN OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: B. WING				
	MHL078-150				R-C 01/12/2023	
NAME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
HOPE HOUSE		D LOWERY RO DN, NC 28386	DAD			
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 513 Continued From p	bage 13	V 513				
ALTERNATIVE						
	hall provide services/supports					
	fe and respectful environment.					
These include:						
	e least restrictive and most					
	appropriate settings and methods;					
	(2) promoting coping and engagement skills that are alternatives to injurious behavior to					
self or others;						
	meaningful to the clients served/supported; and					
	(4) sharing of control over decisions with					
	the client/legally responsible person and staff.					
	restrictive intervention					
	ed to reduce a behavior shall					
	panied by actions designed to respect during and after the					
intervention. The						
	e intervention as a last resort;					
and						
(2) employi trained in its use.	ng the intervention by people					
This Rule is not r	net as evidenced by:					
	reviews and interviews, the					
facility failed to pr	ovide services/supports that					
	strictive intervention procedure					
to reduce a behave (#2). The findings	vior for 1 of 2 audited clients are:					
	Review on 1/11/23 of client #2's record revealed:					
-13 year old male						
-Admitted on 6/6/2						
	sruptive Mood Dysregulation					
	umatic Stress Disorder chronic icit Hyperactive Disorder	•				
(ADHD) combined						
rision of Health Service Regulatio						

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI TIPI F	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED	
					R	-C	
		MHL078-150	B. WING			12/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
HOPE H	OUSE		LOWERY RO	DAD			
	1		N, NC 28386				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
V 513	Continued From pa	ge 14	V 513				
	client #2 dated 9/20 -"Description: At Ap [Client #2] were sitti redirected [Client #2 conversation with a #2] immediately sto entry and began to Professional] gently room to review his a continued to ignore [Client #2] to get his scheduled requiring therapy. [Client #2] table and ignore Sta performed the NCI approved one man appropriately 1 minu #2] to the van" Interview on 1/11/22 -He could not reme -He told staff #11 he -Staff #11 "carried" Interview on 1/12/22 -She placed client # he refused to "get u -Client #2 did not w had to put him in th -She physically pick to the van.	proximately 3:50pm Staff and ing at the kitchen table. Staff 2] for being intrusive in her nother Staff member. [Client pped writing in his journal stare in space[Associate <i>y</i> asked [Client #2] to go to his anger worksheet[Client #2] prompts[Staff #11] asked s things together due to g the group to leavefor group continued to sit at the kitchen aff's directives[Staff #11] (Non Crisis Interventions) therapeutic hold for ute. [Staff #11] assisted [Client 3 client #2 stated: mber exactly what happened. e was not going to therapy. him to the van. 3 staff #11 stated: #2 in a therapeutic hold after up from the table." ant to go to therapy and she e van. ked client #2 up and took him 3 the Associate Professional or a portion of the incident on					

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation				APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	MHL078-150		B. WING			R-C <b>12/2023</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HOPE H	OUSE		D LOWERY RC N, NC 28386	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 513	Continued From pa	ge 15	V 513			
V 736	<ul> <li>Staff #11 asked client #2 if he needed to get his anger worksheet and client #2 ignored her.</li> <li>Staff #11 asked client #2 to get his things together so they could leave for group therapy.</li> <li>Client #2 ignored staff and continued to sit at the table.</li> <li>Staff #11 wrapped client #2 and walked him to the van.</li> <li>Client #2 said he did not want to go.</li> <li>27G .0303(c) Facility and Grounds Maintenance</li> <li>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</li> <li>(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.</li> </ul>		V 736			
	was not maintained and orderly manner Observation on 1/1 during the tour of th -The kitchen cabine discolored. -A brown oval shap above the dining tal -The dining table ha marks. -The wooden floor r hallway entrance wa	on and interview the facility in a safe, clean, attractive The findings are: 1/23 at approximately 2:40pm facility revealed: ets below the kitchen sink were ed spot on the kitchen ceiling				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R-C	
		MHL078-150	B. WING			12/2023
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOPE HO	DUSE		D LOWERY RC DN, NC 28386	DAD		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 736	Continued From pa	ige 16	V 736			
	be broken. -There were several room walls of varies -There was no three bathroom. -Client #3's bedrood holes varying in diff -Client #2's bedrood areas that had not b blinds had broken s Interview on 1/12/2 -She would follow u	shold from the hallway to the m closet doors had several ferent sizes. m wall had several patched been painted. His window slates. 2 the Program Director stated up on the areas of concerns. stitutes a re-cited deficiency				