Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-106	A. BUILDING: _____ B. WING _____	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCA'S HOPE HAVEN	4675 HICKORY LINCOLNTON HWY NEWTON, NC 28658

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V 000	INITIAL COMMENTS A complaint and annual survey was completed on October 10, 2025. The complaint was substantiated (intake #NC00232850). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 4 current clients and 1 former client. A sister facility is identified in this report. The sister facility will be identified as sister facility A. All staff at the facility are related. The Chief Executive Officer/Director/Licensee (CEO/D/L) is the Vice President/Licensee/Qualified Professional's (VP/L/QP's) and Staff #2's Mother. The VP/L/QP and Staff #2 are Sister and Brother. The CEO/D/L is Staff #1's Aunt. Staff #1 and the VP/L/QP and Staff #2 are cousins.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including:	V 105	RECEIVED NOV 12 2025 DHSR-MH Licensure Sect	

Valan Thal / Director 11/8/25

	(A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including:			

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V 105	Continued From page 1 (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting	V 105		

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V 105	Continued From page 2 applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a screening assessment affecting 4 of 4 clients (Clients #1, #2, #3 and #4). The findings are: Review on 9/18/25 of Client #1's record revealed: -Date of Admission: No date documented. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies. -Age: 19 years. -No documentation of a screening assessment to include an assessment of the individual's presenting problem or need. Review on 9/18/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age: 12 years. -No documentation of a screening assessment to include an assessment of the individual's	V 105	**V105** Moving Forward Luca's Hope Haven will utilize its admissions and intake criteria to screen and determine if a potential client meets our inclusionary criteria for the overall program. This process will determine whether the program can meet the clients needs. All applicants or potential new admissions will be required to go through the facility screening process. The screening process includes; submitting an application, updated Comprehensive clinical assessment for review, a signed service order, including a current PCP,including Physicians orders in regards to medications that would be administered to the client. These documents will be reviewed by the Director and the QMHP to determine if the potential client can be accepted into the program. Upon determining whether a client can be admitted, the facility must receive the following documents; Birth Certificate, social security card, copy of insurance or medicaid card. All documents mentioned above must be received by the facility before the intake process takes place and the client is admitted. Adhering to our intake process will ensure that the facility can provide adequate services while also ensuring that staff are made knowledgeable of clients' diagnosis,history and potential behaviors in order for clients to receive appropriate care. The facility will ensure that client information is documented and maintained including adhering to our policies for intakes regardless of the situation. The facility will include performing meet and greet sessions for all potential clients as part of the assessment to determine if the facility can meet clients needs. The assessment will be completed by the QMHP before the decision about a client's admission can be made.	

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V 105	Continued From page 3 presenting problem or need. Review on 9/18/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. -No documentation of a screening assessment to include an assessment of the individual's presenting problem or need. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnoses: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. -No documentation of a screening assessment to include an assessment of the individual's presenting problem or need. Interview on 9/23/25 with the Vice President /Licensee/Qualified Professional (VP/L/QP) revealed: -She was the QP and has been in this role since 2023. -Part of her duties included completing screening assessments for the facility. Interview on 10/6/25 with the Chief Executive Officer/Director/Licensee (CEO/D/L) revealed: -"I am the one contacted and I asked for an updated CCA (Comprehensive Clinical Assessment) and PCP (Person Centered Plan) for a history and we (CEO/D/L and VP/L/QP) kind of look at it and decide from that (on admissions)."	V 105		

	-"I thought because we were under the same			

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V 105	Continued From page 4 umbrella (Licensee) we weren't doing discharges or admissions (to sister facilities)." -"I didn't know (about the need for screening assessments) but I will (complete screening assessments) from now on (when I move a client from one facility to a sister facility)." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 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 trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108		

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V 108	Continued From page 5 equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 4 audited paraprofessionals (Staff #1 and #2) and 1 of 1 former paraprofessionals (Former Staff (FS) #1) received training to meet the MH/DD/SA needs of the clients. The findings are: Review on 9/18/25 of Staff #1's record revealed: -Hire Date:12/13/23. -Job: Residential Counselor. -No documentation of training of client specific mh/dd/sa needs training and no documentation to address the sexually aggressive youth for Clients # 1, # 2, # 3 and # 4. Review on 9/18/25 of Staff #2's record revealed: -Hire Date:7/9/19. -Job: Residential Counselor. -No documentation of training for client specific needs to reflet the treatment plans and no documentation to address the sexually aggressive youth for Clients # 1, # 2, # 3 and # 4. Review on 9/18/25 of Former Staff #1's record revealed: -Hire Date:5/30/25. -Date of Separation:7/15/25.	V 108	**V108** The facility will ensure that all staff will receive upon hiring and maintain annually training for CPR, First Aide training,Bloodborne Pathogens training, Emergency Action Procedures, Safety classes, clients rights, confidentiality, EBPI,Abuse &mNeglect, Medication Administration(**Medication administration training will include demonstrating a medication pass being observed by a nurse**), seizure management, Client specific, Documentation, and goal planning. There will also be a minimum of 12 in-service training hours required per year. This also includes continuing education that may be necessary in areas that will benefit the care of clients and quality of the facility.This will be monitored by the Director and the QMHP. Quarterly Record reviews will be completed on all staff training records ensuring that all required classes and training are kept current. Luca's Hope Haven will utilize training services from outside resources and in-house resources from the QMHP.	

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V 108	Continued From page 6 -Job: Residential Counselor. -No documentation of training for client specific needs to reflect the treatment plans and no documentation to address the sexually aggressive youth for Clients # 1, # 2, # 3 and # 4. Review on 9/18/25 of Client #1's record revealed: -Date of Admission: None documented. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies -Age: 19 years. -Assessment dated 6/6/23 revealed: client struggles with respecting boundaries of others, including inappropriate sexualized behaviors, pornography. Review on 9/18/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age: 12 years. -Assessment dated 10/14/22 revealed: displayed verbal and physical aggression in the home, including inappropriate sexualized behaviors. Witnessed domestic violence against his mother, lack of basic needs in the home, was acting out sexually on his younger sister. Review on 9/18/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. -Placement Referral dated 7/17/24 revealed: history of sexual relationship with his older sister; family history of substance abuse.	V 108		

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V 108	Continued From page 7 Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. -Admission Application dated 1/28/25 revealed history of sexualized behaviors of inappropriate pictures being sent. Interview on 10/8/25 with Staff #1 revealed: -Training on client needs consisted of "...I would go to the office and read their CCA (comprehensive clinical assessment) and I would try to ask [Chief Executive Officer/Director/Licensee (CEO/D/L)] as many questions as I can about the client." -If there was a new admission, "I would get a phone call from [CEO/D/L]." Interview on 10/8/25 with Staff #2 revealed: -"We read and discuss their (clients) file (before admissions)." -"We have trainings, and we go over client files." -"The goals are right there on the computer at the house (facility) and can be viewed." Interview on 10/6/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"We (CEO/D/L and VP/L/QP) make staff familiar with each of the kids (clients) and each of their diagnosis." -"...Staff are aware of what is going on with these kids and there are conversations going on at our meetings." -"That (documentation) isn't in our program (the staff aren't signing off that they have been trained on client specific needs), it's just something we	V 108		

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V 108	Continued From page 8 have shared (discussed with staff)." Interview on 10/6/25 with the CEO/D/L revealed: -"We (CEO/D/L and VP/L/QP) would tell them (new staff) about the clients." -"We (CEO/D/L and VP/L/QP) update a new person (staff) on what to look for or what their triggers are or what their goals are." -"Things are told (to staff) but we are not documenting." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 109		

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V 109	Continued From page 9 (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 Qualified Professional (Vice President/Licensee/Qualified Professional (VP/L/QP)) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients. The findings are: Review on 9/18/25 of the VP/L/QP's record revealed: -Date of hire: 8/7/23. -Title/Position: QP Review on 9/17/25 of the VP/L/QP's job description signed on 8/7/23 revealed: -"Work in conjunction with these individuals, other professionals, consultants and staff in developing, implementing, documenting,	V 109	**V109** The hired consultant will ensure that the Qualified Professional will meet the requirements and demonstrate knowledge and competence by exhibiting the following skills: technical knowledge, cultural awareness, analytical skills,decision-making, interpersonal skills, communication skills, and clinical skills. The consultant will monitor and supervise the Qualified Mental Health Professional and the director. Ensuring all responsibilities are being accurately completed within the required timeframe. This will be done by weekly administrative meetings and monthly staff meetings that are mandatory. Working with a hired consultant will ensure that the QMHP gains knowledge needed to ensure admission and discharge procedures are followed according to policy. Can Coordinate admissions and discharges with the appropriate staff. Can ensure, through regular audits, that accurate and timely documentation is occurring and that client records are maintained according to policy. Can prepare and submit required or requested reports, documents, assessments, evaluations and paperwork. Review and sign off on clinical documentation as Required. Can continuously use person-centered approaches and positive approach strategies when interacting with consumers. Can Integrate strategies into program plans. Can provide direction and supervision to staff, monitor performance and implementation of the responsibilities by being present when day-to-day activities; routines and rhythms are taking place, on all shifts and by unannounced visits. Can ensure staff are appropriately trained regarding plans and demonstrate an understanding of specific plan components. Utilizing a hired consultant will improve the QMHP knowledge and Competence in the required skills	

	monitoring and adjusting the plan of care and related programs. -Ensure admission and discharge procedures are			

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V 109	Continued From page 10 followed according to policy. -Conduct reviews of clinical documentation to ensure that it meets the requirements for the service being provided. -Ensure that client records are maintained according to policy. -Prepare and submit required reports, documents, assessments, evaluations and paperwork. -Provide direction and supervision to staff, monitor performance and implementation of these responsibilities. -Ensure staff are appropriately trained regarding plans and related programs and demonstrate requirements as outlined by area programs." Refer to V105 for evidence that the VP/L/QP failed to complete screening assessments. Refer to V108 for evidence that the VP/L/QP failed to ensure staff received client specific training to meet the MH/DD/SA needs of the clients. Refer to V111 for evidence that the VP/L/Q failed to ensure admission assessments were completed prior to the delivery of services Refer to V112 for evidence the VP/L/QP failed to develop implement treatment plans with current strategies to address the needs of the clients. Refer to V180 for evidence that the VP/L/QP failed to have one direct care staff present and failed to provide clients with clinical consultation by a qualified mental health professional at least twice monthly Refer to V182 for evidence that the VP/L/QP admitted a client who was beyond the age	V 109		

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V 109	Continued From page 11 limitation of 18 years old. Interviews on 9/23/25 and 10/6/25 with the VP/L/QP revealed: -Part of her duties include intake and discharge of clients, supervision of clients and staff, organizing training, and administrative support. -"Both of us (VP/L/QP and Chief Executive Officer/Director/Licensee (CEO/D/L)) are responsible for updating and writing the treatment plans." -"I am back up to [CEO/D/L]." -"I should be responsible (for admission assessments) but we (VP/L/QP and the CEO/D/L) have gone through them together." -"We (VP/L/QP and CEO/D/L) have video conferences with the prospective client and the guardian and the social worker because on paper it reads one day and it might be another scenario that we can't handle the kid. It might be reverse also." -"I will be the one who does the PCP (Person Centered Plan). It's a group effort of the DSS (Department of Social Services) and [CEO/D/L] but in the wheel house that will be me...That's dropping the ball on my end (no treatment strategies)." -"This is an asleep program. They (staff) do have a staff room but they get up and check the rooms every hour or hour and a half but from my understanding, staff can have their bedroom and sleep as long as they are checking." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 109		

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V 110	Continued From page 12	V 110		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, 1 of 3	V 110		

PRINTED: 10/28/2025
FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-106	A. BUILDING: _____ B. WING _____	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCA'S HOPE HAVEN	4675 HICKORY LINCOLNTON HWY NEWTON, NC 28658

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V 110	Continued From page 13 audited paraprofessional staff (Chief Executive Officer/Director/Licensee (CEO/D/L)) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 9/23/25 of the CEO/D/L record revealed: -Date of Hire: 6/2/09. -Job Title: Executive Director. -Job description unsigned and undated: "The duties of the Owner/Executive Director (CEO/D/L) vary within the facility, but are responsible for the success of the company...This position is responsible for ensuring that each consumer receives supports that are individually tailored and flexible..." Refer to V105 for evidence that the CEO/D/L failed to complete screening assessments. Refer to V108 for evidence that the CEO/D/L failed to ensure staff received client specific training to meet the MH/DD/SA needs of the clients. Refer to V111 for evidence that the CEO/D/L failed to ensure admission assessments were completed prior to the delivery of services. Refer to V112 for evidence the CEO/D/L failed to develop implement treatment plans with current strategies to address the needs of the clients. Refer to V180 for evidence that the CEO/D/L failed to have one direct care staff present and failed to provide clients with clinical consultation by a qualified mental health professional at least twice monthly.	V 110	**V110** The hired consultant will ensure that the Qualified Professional will meet the requirements and demonstrate knowledge and competence by exhibiting the following skills: technical knowledge, cultural awareness, analytical skills,decision-making, interpersonal skills, communication skills, and clinical skills. The consultant will monitor and supervise the Qualified Mental Health Professional and the director. Ensuring all responsibilities are being accurately completed within the required timeframe. This will be done by weekly administrative meetings and monthly staff meetings that are mandatory. Working with a hired consultant will ensure oversight into work updating all job descriptions such as the CEO/Director, Qualified Mental Health Professional and Paraprofessional.The job descriptions will be signed by the CEO/ Director and QMHP. Luca's Hope Haven will revise the Admission packet to make sure that the admission date, Intake date, Discharge date, Site/Facility location are clearly listed.	

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V 110	Continued From page 14 Refer to V182 for evidence that the CEO/D/L admitted a client who was beyond the age limitation of 18 years old. Interview on 9/23/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"I am back up to [CEO/D/L]." -"Both of us (VP/L/D and CEO/D/L) are responsible for updating, writing the treatment plans." Interviews on 9/18/25 and 10/6/25 with the CEO/D/L revealed: -"It's up to me to update the plan (treatment plan)." -"I am the one contacted and I ask for a CCA (comprehensive clinical assessment) and PCP (person centered plan) for a history and we (CEO/D/L and VP/L/QP) kind of look at it and decide from that (on admissions)." -"I will make sure I am maintaining the records (client files)." -"Staff are supervised by [VP/L/QP] and myself." -"This is an asleep program." -"They (staff) have to get up multiple times a night...they know how to get up and monitor, which they do." -"They are supposed to get up and check the kids every few hours, making rounds ." -"There is no form for them to fill out when monitoring during the night." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 110		

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V 111	Continued From page 15	V 111		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were completed and failed to ensure when services were provided prior to the establishment and implementation of the treatment/habilitation or service plan, strategies to address the client's presenting problem were documented affecting 4 of 4 clients (Clients #1, #2, #3 and #4). The findings are: Review on 9/18/25 of Client #1's record revealed: -Date of Admission: No date documented. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies. -Age: 19 years. -No documentation of an assessment completed and no documentation of strategies to address the client's presenting problem were developed prior to the establishment and implementation of the treatment/habilitation or service plan. Interview on 10/6/25 with Client #1's Department of Social Services legal guardian revealed: -Admission date into the current facility was 1/17/25. Interview on 10/7/25 with the Local Management Entity/Managed Care Organization (LME/MCO) revealed: -"I was informed on 1/23/25 about the move to Luca's Hope Haven...found out because they called to schedule a new CFT (Child and Family Team Meeting) and it would be at the new	V 111	**V111** The facility will utilize its admissions and intake criteria to screen and determine if a potential client meets our inclusionary criteria for the overall program. This process will determine whether the program can meet the clients needs. All applicants or potential new admissions will be required to go through the facility screening process. The screening process includes; submitting an application, updated Comprehensive clinical assessment for review, a signed service order, including a current PCP.The facility will ensure that all assessments and treatment plans will be completed within 30 days of admission and will continue being updated on a monthly basis by the QMHP and supervised by the Director.	

	location." Review on 9/18/25 of Client #2's record revealed: -Date of Admission: 2/15/25.			

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V 111	Continued From page 17 -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age: 12 years. -No documentation of an assessment completed and no documentation of strategies to address the client's presenting problem were developed prior to the establishment and implementation of the treatment/habilitation or service plan. Review on 9/18/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. -No documentation of an assessment completed and no documentation of strategies to address the client's presenting problem were developed prior to the establishment and implementation of the treatment/habilitation or service plan. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. -No documentation of an assessment completed and no documentation of strategies to address the client's presenting problem were developed prior to the establishment and implementation of the treatment/habilitation or service plan. Interview on 10/8/25 with Staff #2 revealed: -"Whenever a client comes (admitted)...we read and discussed his file." -"At staff meetings...we go over client files." -"The goals are right there on the computer at the house (facility) and can be viewed."	V 111		

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V 111	Continued From page 18 Interview on 10/8/25 with Staff #1 revealed: -"I would go to the office and read their CCA (comprehensive clinical assessment) and I would try to as [Chief Executive Officer/Director/Licensee (CEO/D/L)] ask many questions as I can about the new client and his behaviors." Interviews on 9/23/25 and 10/6/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -Started working as the facility's QP in 2023. -She was responsible for client intake and discharge . -"I should be responsible (for admission assessments) but we have gone through them (admissions) together (VP/L/QP and CEO/D/L))." Interview on 10/6/25 with the CEO/D/L revealed: -"[VP/L/QP] is responsible for the admissions assessments." -"I thought because we were under the same umbrella (Licensee) and we weren't doing discharges or admissions (to sister facilities)." -"I didn't know, but I will from now on." -"I was not aware of the requirement to have a waiver and I have not requested one."	V 111		
V 112	This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days. 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE	V 112		

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V 112	Continued From page 19 PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement the treatment plan with current strategies to address the needs of 4 of 4 clients (Clients #1-4). The findings are: Review on 9/18/25 of Client #1's record	V 112	**V112** The facility will utilize its admissions and intake criteria to screen and determine if a potential client meets our inclusionary criteria for the overall program. This process will determine whether the program can meet the clients needs. All applicants or potential new admissions will be required to go through the facility screening process. The screening process includes; submitting an application, updated Comprehensive clinical assessment for review, a signed service order, including a current PCP.The facility will ensure that all assessments and treatment plans will be completed within 30 days of admission and will continue being updated on a monthly basis by the QMHP and supervised by the Director.	

	revealed: -Date of Admission: No date documented. -Diagnoses: Attention Deficit Hyperactivity			

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V 112	Continued From page 20 Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies -Age: 19 years. -Employed at grocery store and works three days a week. -No documentation of supervision needs. -No documentation of treatment strategies developed or implemented to address the client's needs. Review on 9/18/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age: 12 years. -No documentation of treatment strategies developed or implemented to address the client's needs. Review on 9/18/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. -No documentation of treatment strategies developed or implemented to address the client's needs. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. -No documentation of treatment strategies developed or implemented to address the client's needs.	V 112		

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V 112	Continued From page 21 Interviews on 9/23/25 and 10/6/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"I am responsible for scheduling treatment team meetings." -"Both myself and [Chief Executive Officer/Director/Licensee (CEO/D/L)] are responsible for treatment plans." -"That's dropping the ball on my end (treatment plans not being current)." Interview on 9/17/25 with the CEO/D/L revealed: -"We have CFTs (Child and Family Team meetings), and I can show you that, but I haven't updated the PCP (person centered plan)." -"We haven't been required to submit documentation like we used to "...to the local management entity/managed care organization." -"I have gotten slack on the paperwork (keeping the treatment plans updated)." -"...It's up to me to update the plan." -"I was not aware of the requirement to have a waiver and I have not requested one."	V 112		
V 113	This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days. 27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number;	V 113		

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V 113	Continued From page 22 (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

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V 113	Continued From page 23 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete records affecting 4 of 4 clients (Clients #1, #2, #3 and #4). The findings are: Review on 9/18/25 of Client #1's record revealed: -Date of Admission: None documented. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies. -Age:19 years. -No current emergency contact information for the legal guardian. -No admission assessment. -No current treatment/habilitation plan. The last treatment plan was developed on 7/23/24 and expired on 7/23/25. -No documentation of services provided. -No documentation of progress toward outcomes. Review on 9/18/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age:12 years. -No current emergency contact information for the legal guardian. -No admission assessment. -No current treatment/habilitation plan. The last treatment plan was developed on 9/11/24 and expired on 9/11/25. -No documentation of services provided. -No documentation of progress toward outcomes. - No documentation of permission to seek emergency care.	V 113	**V113** The facility will ensure that all records and documentation for any client in need of services must provide all required documentation that is required to be in their file. This includes a copy of a physician's order for medication,copy of birth certificate, Copy of Insurance or medicaid card, Emergency contact and a completed application. Luca's Hope Haven will revise and update Client intake packet to ensure the following client information which will have an identification face sheet which includes: Name (last, first, middle, maiden); client record number; date of birth; race, gender and marital status; admission date; discharge date; documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; documentation of the screening and assessment; treatment/habilitation or service plan; emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician, documentation of progress toward outcomes; if applicable: documentation of physical disorders diagnosis according to International Classification of Diseases,medication orders; orders and copies of lab tests; and documentation of medication and administration errors and adverse drug reactions. Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. Luca's Hope Haven will ensure that only qualified personnel will be documenting on the new client intake forms and process This will be monitored by the CEO/Director and QMHP	

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V 113	Continued From page 24 Review on 9/18/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. -No admission assessment. -No current treatment/habilitation plan. -No documentation of services provided. -No documentation of progress toward outcomes. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. - Had contact information for a Department of Social Service's (DSS) legal guardian. -No current treatment/habilitation plan. The last treatment plan was developed on 6/28/24 and expired on 6/27/25 -No documentation of services provided. -No documentation of progress toward outcomes. Interview on 9/22/25 with Client #2's DSS legal guardian revealed: -Confirmed that the name on the contact paperwork at the facility was not the correct contact person for the DSS legal guardian. The person on the paperwork was retired. -The DSS legal guardian currently assigned to Client #2 has been his legal guardian since 2022. Interview on 9/22/25 with Client #4's former DSS legal guardian revealed: -She has not been the legal guardian since August 2025.	V 113		

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V 113	Continued From page 25 Interview on 9/23/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"Both myself and [Chief Executive Officer/Director/Licensee (CEO/D/L)] are responsible for treatment plans." Interview on 10/6/25 with the CEO/D/L revealed: -"[Staff #1] was responsible for filing...complete paperwork, she made mistakes." -"I've never updated the guardian (contact name and phone number) on the face sheet (in the client's record)." -"I am going to go back to doing it myself...it should be my responsibility."	V 113		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118		

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V 118	Continued From page 26 (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure medications were administered on the written order of a person authorized by law to prescribe drugs and failed to keep MARs current affecting 4 of 4 clients (Clients #1, #2, #3 and #4) and failed to ensure medications were administered only by persons trained by a registered nurse, pharmacist or other legally qualified person affecting 3 of 4 current staff (Staff #1, Staff #2, and the Vice President/Licensee/Qualified Professional (VP/L/QP)) and 1 of 1 former staff (FS #1). The findings are: Cross-Reference: 10A NCAC 27G .0203 Medication Requirements (V119) Based on record review, interview, and observation the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 1 of 4 clients (Client #4). Cross-Reference: 10A NCAC 27G .0209	V 118	**V118** The facility completed a class on 9/30/2025 that involved each employee performing a simulated return demonstration on how to give medication to clients. The facility staff demonstrated the return of medication administration while being monitored by a licensed nurse. The facility will set in place a checklist that will be utilized moving forward that will have a list of items that must be provided prior to completing an intake for all new clients being enrolled into the program. This new practice will ensure that a physician order is present to indicate accuracy of the medication that the new client should be taking. This checklist will prevent clients from being enrolled into the facility without physician orders for their prescribed medications. Moving forward the facility will ensure that all medications are reviewed on a regular monthly basis so that expired medications and med errors are monitored so that this will not be an issue moving forward. The facility will review / check all medications to ensure that they are not out of date. The reviews will be completed by the QP or the Director. The facility will also ensure that medications are reviewed and checked to ensure that the prescription and mars are accurate and match the doctor's order. These reviews will be completed by the QP and the Director. The reviews and checks will be done monthly/weekly including the Mars in order to prevent any possible medication errors. The facility has already set in place a checklist that will include The QP or Director reviewing client medications, both psychotropic and regular medications, showing that they are being tracked and updated on a 6 month basis to ensure that mediation is being given appropriately as prescribed. The QP will assist the Director with oversight regarding the checklist and monitoring. The Mar will also reflect if a client refuses to take their prescribed medication or if the staff fails to give medication within the window timeframe. Staff will call the pharmacy or the doctor and inform them of the client not getting their medication and get instructions on possible side effects, what to look for because of client taking their medication as prescribed whether it's from them refusing or staff forgetting to give the medication. The facility has already created forms to include the QP & Director whom will monitor and document that these practices mentioned above are being met on a regular basis as stated. There will be more new forms created that will be signed on a weekly/monthly basis effective immediately. To ensure that the above areas that are out of compliance are being met and moving forward will no longer be an issue. This will be completed on a weekly/monthly basis to show that the facility is back in compliance	

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V 118	Continued From page 27 Medication Requirements (V121) Based on record review and interview the facility failed to ensure clients who received psychotropic drugs had a drug regimen review at least every 6 months affecting 4 of 4 clients (Clients #1, #2, #3, and #4). Cross-Reference: 10A NCAC 27G .0209 Medication Requirements (V123) Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 3 of 4 clients (Clients #2, #3, #4). Finding #1 Review on 9/17/25 of Client #1's record revealed: -Physician's orders dated 3/10/25 included the following: -Melatonin 5 milligram (mg) for sleep. -Physician's orders dated 3/26/25 included the following: -Cetirizine hydrochloric acid (HCL) for allergies,10 mg one capsule orally once a day. -Prilosec 40 mg for gastroesophageal reflux disease (GERD), one capsule orally once a day. -Linzess for constipation, 72 micrograms (mcg) one capsule orally once a day. -No physician's orders for Cefdinir 300 mg, take one capsule by mouth twice daily. Review on 9/17/25 of Client #1's September 2025 MAR revealed: -Cetirizine HCL 10 mg one capsule orally once a day transcribed without complete instructions to include the route of administration. -Prilosec 40 mg one capsule orally once a day as transcribed without complete instructions to include the route of administration.	V 118		

	-Linzess 72 mcg one capsule orally once a day was transcribed without complete instructions to			

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V 118	Continued From page 28 include the route of administration. -Melatonin 5 mg one at bedtime as needed was transcribed without the complete instructions to include the route of administration, and the correct quantity of the medication and how many tablets the client was administered. Review on 9/17/25 of Client #2's record revealed: -Physician's order dated 7/13/23 included the following Melatonin 5 milligram (mg) 1-2 tablets at bedtime as needed for sleep. -No physician's orders for Mucinex or Chloraseptic throat spray. Review on 9/17/25 of Client #2's September 2025 MAR revealed: -Melatonin 5 mg 1-2 at bedtime as needed for sleep was transcribed without complete instructions and there was no documentation of how many tablets were administered nightly. how many tablets the client was administered. -Hydroxyzine 25 mg one tablet by mouth 30 minutes before bed was transcribed without complete instructions. Review on 9/17/25 of Client #2's May-June 2025 MAR revealed: -Hydroxyzine 25 mg was not initialed as administered on 6/6/25. No documentation of why the dose was missed. -Mucinex was administered on 5/20/25 at 3:20 pm and 8:10 pm. -Chloraseptic throat spray was administered on 5/20/25 at 8:11 pm. -Mucinex was administered on 5/21/25 at 8:06 pm. Review on 9/17/25 of Client #3's record revealed: -Physician's order dated 8/15/24 included the following:	V 118		

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V 118	Continued From page 29 -Loratadine for allergies,10 mg 1 tablet by mouth daily. -Docusate for constipation 100 mg 1 (100mg) by mouth every morning. -Physician's order dated 4/17/25 included the following: -Cephalexin 250 mg/5 milliliters (ml) oral suspension 8 ml orally BID (twice daily) for 10 days. Review on 9/17/25 of Client #3's April 2025- September 2025 MARs revealed: -Guanfacine HCl extended release (ER), 4 mg 1 tablet daily at bedtime used to treat attention deficit hyperactivity disorder. -Docusate for constipation, 100 mg in the morning. -Trazadone for insomnia, 50 mg 1 tablet daily at bedtime was to treat insomnia. -Sertraline for post-traumatic stress disorder, 50 mg 1 tablet by mouth daily used to treat post-traumatic stress disorder. -Montelukast 4 mg 1 by mouth every evening used to reduce allergy/asthma symptoms were transcribed without complete instructions to include the route of administration. -Loratadine 10 mg 1 tablet by mouth daily as needed to treat allergies was transcribed without complete instructions to include the route of administration or reason to administer. Review on 9/17/25 of Client #3's May 2025-September 2025 MARs revealed: -Vyvanse for attention deficit hyperactivity disorder (ADHD) 30 mg in the morning. Review on 9/17/25 of Client #4's April 2025- September 2025 MARs revealed: -Atomoxetine e 40 mg 1 tablet twice a day. -Trazadone 50 mg 1 tablet at bedtime.	V 118		

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V 118	Continued From page 30 -Cetirizine HCl 10 mg was transcribed without completed instructions to include no route of administration. Review on 9/17/25 at 10:20 am of Client #4's medications revealed: -Cetirizine 10 mg used to treat allergy relief had no expiration date on the bottle. -Ventolin HFA 1 putt q 4 PRN (as needed) used to treat shortness of breath was dispensed on 8/1/23 and expired on 7/31/24. Not listed on the MARs. -Fluticasone 50 mcg 1 spray into each nostril daily, may use 2 times daily was dispensed on 1/10/24 and expires 10/2026; not listed on the MARs. -Biofreeze Gel 4% 1 application two times per day to external right shoulder as needed, no PRN reason on label, dispensed 10/23/23 and expired 10/23/24; not listed on the MARs. Interview on 9/23/25 and 10/6/25 with the Vice President /Licensee/Qualified Professional (VP/D/QP) revealed: -"[CEO/D/L] writes the MARs...we (CEO/D/L and VP/D/QP) review them together." -"I do review and look at MARs, making sure signed off doctors' orders but that is not my wheelhouse or ownership, but I've done it." -"That could be me or [CEO/D /L]...usually it's her (CEO/D/L) but I am definitely called in to make sure meds (medication) are in there." -"The PRNs (as needed) are not listed on the MARs." -"[CEO/D/L] ensures the psychotropic meds are being reviewed...and for the disposal of medications." Interview on 10/6/25 with the CEO/D/L revealed: -"I didn't have a place on the old MAR for the	V 118		

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V 118	Continued From page 31 PRN but I do now." Finding #2 Review on 9/18/25 of Staff #1's record revealed: -Date of Hire:12/13/23. -Medication administration training dated 4/30/25 signed by the Registered Nurse (RN) Medication Training Consultant. Review on 9/18/25 of Staff #2's record revealed: -Date of Hire:7/9/19. -Medication administration training dated 4/30/25 signed by the RN Medication Training Consultant. Review on 9/18/25 of the VP/L/QP's record revealed: -Date of Hire:2/21/23. -Medication administration training dated 4/30/25 signed by the RN Medication Training Consultant. Review on 9/18/25 of FS #1's record revealed: -Date of Hire:5/30/25. -Medication administration training dated 4/30/25 signed by the RN Medication Training Consultant. Interview on 9/29/25 with Staff #2 revealed: -Was trained in medication administration. -"We talked about it (administering medications) and then we would take a test." -"If I remember correctly, it was either her (RN) or [CEO/D/L] (that observed us administer medications)." Interview on 9/23/25 with Former Staff #2 revealed: -"I passed (administered) medications." -"[CEO/D/L] observed me pass (administer) medications." -"We had discussions and a written test (in the medication administration training)."	V 118		

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V 118	Continued From page 32 -"[CEO/D/L] had a person come train us." -"PRNs we would write it on the MARs and log that we gave it to them." Interview on 9/22/25 with the facility's RN Medication Training Consultant revealed: -"I conduct the medication administration training." -"I haven't ever actually observed a medication pass." -"I rely some on [CEO/D/L]. She ensures me that she works with them (staff) individually (after the staff complete the medication administration classroom instruction) before they can give (administer) medications." Interview on 9/23/25 with the VP/L/QP revealed: -"Medication Administration training is done by a Registered Nurse." -"An entire day of training, a lot of hands on display, study time and then testing time to make sure everyone is able to do this (administer medications)." -"A senior staff will make sure they can do it (administer medications), most of the time it's [CEO/D/L]." -"Staff are watched (by CEO/D/L) passing (administering) medications on shift for about 5 days or however many days they are on that week." Interview on 10/6/25 with the CEO/D/L revealed: -"I wasn't aware that it (medication administration observed by a RN) had to be a part of the training." -"The nurse (RN Medication Training Consultant) came and did it for me...she came last week and did everybody's (training)." Review on 9/24/25 of the Plan of Protection	V 118		

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V 118	Continued From page 33 (POP) dated and signed by the CEO/D/L on 9/24/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will get the Nurse (RN Medication Training Consultant) to come to the home today by 6pm and watch myself and at least one other direct care staff observe a return demonstration of how to administer medication to clients. The nurse will give a date of when she can perform another class to observe all of the other staff members who demonstrate how to administer medication. This will be done no later than September 30th. Until this is completed and all the other staff members are retrained, those of us that are certified in medication competency by the RN will be the only ones that will administer medication until everyone has completed this process. Effective immediately all medication that is expired will be disposed of in a proper manner by 8PM today. Moving forward we will ensure that all medications are reviewed on a regular monthly basis so that expired medications and (medication) errors are monitored so that this will not be an issue moving forward. The facility will review/check all medications to ensure that they are not out of date. The facility will also ensure that medications are reviewed and checks will be done monthly, including the mars preventing any medication errors. The medication disposal will be improved by the facility. This will be done by a form being created to include a witness accompanying the staff, including them, signing the form to verify that medication was disposed of. The psychotropic reviews will done no later than September 30th and this will be done on a 6-month basis to ensure that this is prevented from happening again. The QP will assist with oversight of this being set in place and implemented including following through. The	V 118		

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V 118	Continued From page 34 medication errors will include when a client refuses to take the medication or if the staff fails to give medication within the window timeframe, staff will call the pharmacy or the doctor and inform them of the client not getting their medication within the window timeframe, staff will call the pharmacy or the doctor and inform them of the client not getting their medication and get instructions on possible side effects, what to look for because of client not getting their medication as prescribed whether its form them refusing or staff forgetting to give the medication. Describe your plans to make sure the above happens. The facility will come up with a form to include the QP (VP/L/QP) & Director (CEO/D/L) who will monitor and document that these practices mentioned above are being met on a regular basis. There will be new form created that will be signed on a weekly basis starting/effective September 26th (2025) to ensure that the above areas that are out of compliance are being met and moving forward will not be an issue. This will be completed on a weekly basis to show that we are back in compliance." This facility served children aged 10-19 years old with diagnoses which included Attention Deficit Hyperactivity Disorder, Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies, Adjustment Disorder, Unspecified Mental Disorder, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. From January 2025 to September 2025 there were missing physician's orders in the clients' record, medications were transcribed on the MARs without complete instructions to include the route of administration and the correct	V 118		

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V 118	Continued From page 35 quantity of the medication. There was no documentation of why doses had been missed or any documentation of notifying the pharmacist or physician. Medications were being administered by 3 current staff who had not received the required training in medication administration by a registered nurse, pharmacist, or other legally qualified person. The facility failed to dispose of expired medications affecting 1 of 4 current clients. Observation of expired medications in Client #4's lock box included BioFreeze and Ventolin inhaler. There was no protocol on medication disposal. There was no documentation of a drug regimen review for 4 of 4 current clients. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.	V 119		

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V 119	Continued From page 36 (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on record review, interview, and observation the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 1 of 4 audited clients (Client #4). The findings are: Observation on 9/17/25 at approximately 10:20am of Client #4's medication revealed: -Ventolin HFA 1 puff q (every) 4 hours PRN (as needed) shortness of breath dispensed 8/1/23 expired 7/31/24 . -Biofreeze Gel 4% 1 application twice daily to external right shoulder PRN dispensed 10/23/23 expired 10/23/24. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnoses: Attention Deficit Hyperactivity Disorder, predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and	V 119	**V119** Luca's Hope Haven will ensure that all prescription and non-prescription medications are disposed of in full compliance with 10A NCAC 27G .0209(d) to prevent diversion or accidental ingestion.The Director and QMHP will immediately update the facility's Medication Disposal Policy to clearly outline disposal methods for both controlled and non-controlled substances Only trained and authorized staff members (House Manager QP, or TheDirector) will conduct and document medication disposals. A second staff member will witness and sign each disposal entry. A Medication Disposal Log will be maintained in the medication administration record (MAR) binder. Upon client discharge, all remaining medications will be promptly disposed of within 24 hours unless the client is expected to return within 30 days. No medications will be stored beyond this period.All staff involved in medication administration will receive refresher training on medication storage, disposal, and documentation procedures.The QP and consultant nurse will review disposal records Monthly to ensure compliance and proper witnessing. Monthly audits will be conducted by the Director and or QMHP to verify that all medication disposal procedures are being followed and documentation is complete and accurate.Through these corrective measures, the facility will maintain secure medication management practices that safeguard against diversion, accidental ingestion, and regulatory non-compliance.	

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V 119	Continued From page 37 Stressor-Related Disorder. -Age: 17 years. -Physician's orders dated 8/1/23 included Ventolin HFA 1 puff q (every) 4 hours PRN (as needed) for shortness of breath, expired 7/31/24 and not listed on the Medication Administration Record (MARs). -Physician's orders dated 10/23/23 included Biofreeze Gel 4% 1 application BID to external right shoulder as needed, expired 10/23/24 and not listed on the April 2025-September 2025 MARs. Interview on 9/19/25 with Client #4 revealed: -He used the Bio Freeze gel " ...about 3-4 weeks ago." - Had a rescue inhaler and staff " ...have given (administered) it to me ...It's been a while." Interview on 9/23/25 with the Vice President/Licensee/Qualified Professional revealed: -"The PRN over the counter medications should be looked at weekly for expiration dates." -"[The Chief Executive Officer/Licensee (CEO/D/L)] is responsible for disposal of expired medications. Interview s on 9/23/25 and 10/6/25 with the CEO/D/L revealed: -"I think [Staff #1] just gathered stuff the other day and gave you (Division of Health Service Regulation surveyors) meds (medications) that were expired." -" ...It shouldn't be in the (medication) box because we don't have an order for it (inhaler)." -"I would just take it (expired medications) and there's a box at the pharmacy you can stick it in but I never had a witness." -"This (medication disposal) is something I do and I'm responsible for."	V 119		

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LUCA'S HOPE HAVEN	4675 HICKORY LINCOLNTON HWY NEWTON, NC 28658

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V 119	Continued From page 38 This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 119		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure clients who received psychotropic drugs had a drug regimen review at least every 6 months affecting 4 of 4 clients (Clients #1, #2, #3, and #4). The findings are: Review on 9/17/25 of Client #1's record revealed: -Date of Admission: None documented. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid	V 121	**V121** Luca's Hope Haven will ensure full compliance by establishing a consistent and verifiable process for semiannual (Every 6 Months) psychotropic medication reviews conducted by a licensed pharmacist or physician.The facility's Medication Management Policy has been updated to include a mandatory drug regimen review every six months for each client prescribed psychotropic medication.A Medication Review Log will be maintained and kept in the client's record.The on-site manager or Qualified Professional (QP) will notify each client's treating physician within three business days of receiving the pharmacist's review if medical intervention or prescription changes are recommended. Documentation of this communication will be kept in the client's chart.The Director and QP will conduct quarterly audits of medication records to verify that psychotropic medication reviews are completed, filed, and follow-up actions documented appropriately. The consultant pharmacist will also provide a summary report after each review cycle for administrative tracking.Through these corrective actions, the facility will ensure that all clients prescribed psychotropic medications receive regular, documented, and clinically informed medication reviews—protecting client safety, promoting effective treatment, and maintaining full regulatory compliance.	

	Obesity,			

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V 121	Continued From page 39 Seasonal Allergies. -Age: 19 years. -Physician's order dated 3/10/25 for: -Lexapro (antidepressant) 20 milligram (mg), daily. -Clonidine (sleep) 0.1mg, one at bedtime. -No documentation of a drug regimen review in the past six months. -Review of April 2025-September 2025 MARs revealed that the psychotropic medications were administered. Review on 9/17/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age: 12 years. -Physician's orders dated 12/26/24 for: -Hydroxyzine used to treat allergies or anxiety 25mg, take 1 tablet by mouth 30 minutes before bed. -No documentation of a drug regimen review in the past six months. -Review of April 2025-September 2025 MARs revealed that the psychotropic medications were administered. Review on 9/17/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. -Physician's orders dated 2/20/25: -Guanfacine hydrochloride extended release(HCL ER) (ADHD) 4mg, one tablet daily. -Trazadone (insomnia) 50mg one at bedtime. -Sertraline (post-traumatic stress disorder) 50mg, one in the morning. -No documentation of a drug regimen review in	V 121		

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V 121	Continued From page 40 the past six months. -Review of April 2025-September 2025 MARs revealed that the psychotropic medications were administered. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnoses: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. -Physician's order dated 1/31/25: -Trazadone 50mg, one at bedtime. -Atomoxetine 40mg , one in the morning and one at night. -No documentation of a drug regimen review in the past six months. -Review of April 2025-September 2025 MARs revealed that the psychotropic medications were administered. Interview on 9/23/25 with the Vice President/Licensee/Qualified Professional revealed: -"[Chief Executive Officer/Director/Licensee (CEO/D/L)] is responsible for psychotropic med (medication) reviews." Interview on 10/6/25 with the CEO/D/L revealed: -"I set the appointments and they (clients) have to see a doctor in order to get their medication." -"They (clients) have to see a doctor in order to get their medication." -"They (mental health providers) never stopped their medication management with them (clients)." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements	V 121		

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V 121	Continued From page 41 (V118) for a Type B rule and must be corrected within 45 days.	V 121		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 3 of 4 clients (Clients #2, #3, #4). The findings are: Review on 9/17/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Age: 12 years. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Physician's order dated 12/26/24 included the following: hydroxyzine 25 milligram (mg), 1 tablet by mouth 30 minutes before bed. -No evidence of consultation with a pharmacist or physician for medication errors.	V 123	**V123** Luca's Hope Haven has updated and revised its MAR that is used to document administration of medication to its clients.Luca's Hope Haven will ensure that all medication errors, refusals, and adverse drug reactions are reported and documented in compliance to maintain client safety and meet state regulatory standards.Luca's Hope will immediately notify the physician or pharmacist upon discovery of any medication error or adverse reaction, regardless of severity. The facility will ensure that medication refusals are charted in the client's MAR at the time of occurrence.The staff discovering the medication error will immediately notify the on-call physician or pharmacist and document the time and method of contact.The Director and QP must be notified within 24 hours for review and follow-up. A Medication Error and Reaction Log has been created and will be maintained with each client's Medication Administration Record (MAR). All staff responsible for medication administration have received immediate refresher training on proper medication error procedures, notification requirements, and documentation standards. Training was conducted by the facility's consultant nurse and QP within seven days of this corrective plan and then annually thereafter.The Director and or QP will perform weekly audits of MARs and error logs for 60 days to ensure full adherence to the updated policy. After the initial period, audits will continue monthly as part of the facility's ongoing quality assurance process. Through these corrective actions, the facility will ensure that all medication errors, adverse reactions, and refusals are reported promptly, documented accurately, and addressed immediately to safeguard residents' health and maintain full compliance with state regulations.	

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V 123	Continued From page 42 Review on 9/17/25 of Client #2's June 2025 Medication Administration Record (MAR) revealed: -Hydroxyzine 25 mg used to treat allergies or anxiety was not initialed as administered on 6/6/25. Review on 9/17/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Age: 10 years. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Physician's orders dated 8/20/25 for Montelukast 4mg one daily in the evening. -Physicians orders dated 2/20/25 for Trazadone (insomnia) 50 mg one tablet daily in the evening and Sertraline (post-traumatic stress disorder) 50mg one tablet in the morning. -Physician's orders dated 8/15/24 for Loratadine (allergies) 10mg one daily PRN (as needed). -No evidence of consultation with a pharmacist or physician for medication errors. Review on 9/17/25 of Client #3's April 2025- September 2025 MARs revealed: -Montelukast initialed as administered in the morning instead of in the evening. -Montelukast 4 mg not initialed as administered 6/30/25, 8/30/25 or 8/31/25. -Trazadone 50 mg not initialed as administered on 6/29/25 or 6/30/25. -Sertraline 50 mg each morning not initialed as administered 6/28/25, 6/29/25 or 6/30/25. -Loratadine not initialed as administered 8/31/25. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Age: 17 years. -Diagnoses: ADHD Predominantly Hyperactive	V 123		

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V 123	Continued From page 43 Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Physician's orders dated 12/19/24 included the following: Cetirizine HCl 10 milligrams (mg) one daily. -Physician's orders dated 1/30/25 included the following: Atomoxetine 40 mg 1 tablet twice a day, Trazadone 50 mg 1 tablet at bedtime. -No evidence of consultation with a pharmacist or physician for medication errors. Review on 9/17/25 of Client #4's April 2025- September 2025 MARs revealed: -Atomoxetine 40 mg 1 tablet twice a day was initialed as being administered once instead of twice per day on 4/2/25-4/4/25 and 4/6/25-4/30/25. -Trazadone 50 mg 1 tablet at bedtime was initialed as being administered on 6/31/25. Interview on 10/6/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"I do review and look at MARs, making sure signed off." -"It's not my wheelhouse or ownership but I've done it (reviewed MARs)...That could be me or [Chief Executive Officer/Licensee/Director (CEO/D/L)]." Interview on 10/6/25 with the CEO/D/L revealed: -"I know my MAR didn't reflect anything on where to document (medication refusals/missed medications)." -"Moving forward, there's a place for it (on the MARs)." -"They (staff) would call the doctor or pharmacist and they can let them know (if a medication has been missed)."	V 123		

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V 123	Continued From page 44 -"Me and [VP/L/QP] would be responsible for that." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule and must be corrected within 45 days.	V 123		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed before hiring affecting 1 of 1 qualified professional (Vice President/Licensee/Qualified Professional (VP/L/QP)) and 2 of 3 audited paraprofessionals (Staff #1 and Staff #2). The findings are: Review on 9/8/25 of Staff #1 's record revealed: -Hire date: 12/13/24. -HCPR accessed: 12/14/24. Review on 9/18/25 of Staff #2's record revealed:	V 131	**V131** Luca's Hope Haven will ensure that before hiring any employee/staff, their information shall be entered into the Health Care Personnel Registry verifying whether they are eligible to provide services within the healthcare facility. This will be monitored by the CEO/Director and the QMHP	

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V 131	Continued From page 45 -Hire date: 9/6/23. -HCPR accessed: 10/5/23. Review on 9/18/25 of the VP/L/QP's record revealed: -Hire date: 8/7/23. -HCPR accessed: 9/8/24. Interview on 9/23/25 with the VP/L/QP revealed: -"[Chief Executive Officer/Director/Licensee (CEO/D/L)] is responsible for accessing the HCPR for newly hired staff. " -"I have helped as well (the HCPR check)." Interview on 10/6/25 with the CEO/D/L revealed: -"I'm responsible for that (HCPR checks)." -"I know that should be done before they (staff) are hired." -Staff was hired and waiting to begin work, they started later than what was originally thought and "I didn't think I needed to change the hire date for staff...it was a mistake on my	V 131		
V 133	part (the HCPR check), that's my fault." G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is	V 133		

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V 133	Continued From page 46 conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered	V 133		

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V 133	Continued From page 47 by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was	V 133		

	committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone			

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V 133	Continued From page 48 shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and	V 133		

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V 133	Continued From page 49 Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed	V 133		

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V 133	Continued From page 50 fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete a criminal background check within five business days of making a conditional offer of employment affected 1 of 3 audited paraprofessionals (Staff #2). The findings are: Review on 9/18/25 of Staff # 2's record revealed: -Hire date: 9/6/23. -Criminal background requested: 10/5/23. Interview on 9/23/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"[Chief Executive Officer/Director/Licensee (CEO/D/L)] is responsible for the criminal background checks...I have helped as well (do the background check)." Interview on 10/6/25 with the CEO/D/L revealed: -"I'm responsible for background checks." -"I know that should be done before they	V 133	**V133** Luca's Hope Haven will ensure that before an offer of employment is made to a potential staff/employee a criminal history record check of the applicant will be performed to determine whether they are eligible for hire 5 days before making a conditional offer of employment. All criminal background requests will be performed and monitored by the Director/CEO	

	(staff) are hired." -Staff was hired and waiting to begin work, they started later than what was originally thought and "I didn't think I needed to change the hire date for staff...it was a mistake on my part (the			

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V 133	Continued From page 51 background check), that's my fault."	V 133		
V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care.	V 179		

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V 179	Continued From page 52 This Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to provide a structured living environment within a system of care approach for adolescents who have diagnoses of mental illness, emotional disturbance or other disabilities, affecting 4 of 4 clients (Client #1, #2, #3, and #4). The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review and interview, the facility failed to have screening assessments affecting 4 of 4 clients (Clients #1, #2, #3 and #4). Cross Reference: 10A NCAC 27G .0202 Staff Training (V108).Based on record review and interview, the facility failed to ensure 2 of 4 audited paraprofessionals (Staff #1 and #2) and 1 of 1 former paraprofessionals (Former Staff (FS) #1) received training to meet the MH/DD/SA needs of the clients. Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interview, 1 of 1 Qualified Professional (Vice President/Licensee/Qualified Professional (VP/L/QP)) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients. Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review and interview, 1 of 3 audited	V 179	**V179** The facility will utilize its admissions and intake criteria to screen and determine if a potential client meets our inclusionary criteria for the overall program. This process will determine whether the program can meet the clients needs. All applicants or potential new admissions will be required to go through the facility screening process. The screening process includes; submitting an application, updated Comprehensive clinical assessment for review, a signed service order, including a current PCP. These documents will be reviewed by the Director and the QMHP to determine if the potential client can be accepted into the program. Upon determining whether a client can be admitted, the facility must receive the following documents; Birth Certificate, social security card, copy of insurance or medicaid card. All documents mentioned above must be received by the facility before the intake process takes place and the client is admitted. The facility has begun to utilize an outside professional consultant as of October 17th 2025. The facility is working with the consultant to monitor our progress with meeting the requirements in the plan of protection. The hired consultant will ensure that the qualified professional will meet the requirements and demonstrate knowledge and competence. The consultant will monitor and supervise the qualified mental health professional and the director. The facility will ensure that the clients will receive clinical services 2 times monthly from a licensed therapist. The facility will ensure that all records and documentation for all potential clients will provide all required documentation before being accepted into the program All of this will be monitored by the QMHP and the director supervised by the hired consultant.	

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NAME OF PROVIDER OR SUPPLIER

LUCA'S HOPE HAVEN

STREET ADDRESS, CITY, STATE, ZIP CODE

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NEWTON, NC 28658

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V 179	Continued From page 53 paraprofessional staff (Chief Executive Officer/Director/Licensee (CEO/D/L)) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record review and interview, the facility failed to ensure assessments were completed prior to the delivery of services affecting 4 of 4 clients (Clients #1, #2, #3 and #4). Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interview, the facility failed to develop and implement the treatment plan with current strategies to address the needs of 4 of 4 clients (Clients #1, #2, #3, and #4). Cross Reference: 10A NCAC 27G .1302 Staff (V180). Based on observation, record review and interview, the facility failed to have one direct care staff present with up to 4 clients and failed to provide clients with clinical consultation by a qualified mental health professional at least twice monthly affecting 3 of 4 clients (Clients #1, #2, and #3). Cross Reference: 10A NCAC 27G .1303 Operations (V 182). Based on record review, interview and observation, the facility admitted a client who was beyond the age limitation of 18 years old affecting 1 of 4 clients (Client #1). Review on 10/10/25 of the Plan of Protection dated and signed by the CEO/D/L on 10/10/25 revealed:	V 179		

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V 179	Continued From page 54 What immediate action will the facility take to ensure the safety of the consumers in your care? "(V179/V105) The facility will utilize its admissions and intake criteria to screen and determine if a potential client meets our inclusion criteria for the overall program. This process will determine whether the program can meet the clients needs. All applicants or potential new admissions will be required to go through the facility screening process. The screening process includes; submitting an application, updated Comprehensive clinical assessment for review, a signed service order, including a current person centered plan. These documents will be reviewed by the Director (Chief Executive Officer/Director/Licensee) and the QMHP (Vice President/Licensee/Qualified professional) to determine if the potential client can be accepted into the program. Upon determining whether a client can be admitted, the facility must receive the following documents; Birth Certificate, social security card, copy of insurance or Medicaid card. All documents mentioned above must be received by the facility before the intake process takes place and the client is admitted. (V108) The facility will ensure that all staff will receive upon and maintain annually training for CPR (cardiopulmonary resuscitation), First Aide training, Bloodborne Pathogens training, Emergency Action Procedures, Safety classes, clients rights, confidentiality, EBPI (evidence based protective interventions), Medication Administration, seizure management, Client specific, Documentation, and goal planning. There will also be a minimum of 12 in-service training hours required per year. This also includes continuing education that may be necessary in areas that will benefit the care	V 179		

	of clients and quality of the facility. This will be monitored by the Director and the QMHP.			

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V 179	Continued From page 55 Quarterly Record reviews will be completed on all staff training records ensuring that all required classes and training are kept current. (V109-V110) The facility will ensure that the Qualified Professional will meet the requirements and demonstrate knowledge and competence by exhibiting the following skills: technical knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills, and clinical skills. The Director will monitor and supervise the Qualified Mental Health Professional. Ensuring all responsibilities are being accurately completed within the required timeframe. This will be done by weekly administrative meetings and monthly staff meetings that are mandatory. (V111/V112) The facility will ensure that all assessments and treatment plans will be completed within 30 days of admission and will continue being updated on a monthly basis by the QMHP and supervised by the Director. V(180) The facility will ensure that all clients receiving services will be enrolled with a mental health provider for clinical consultation within 30 days of admission. The QMHP will initiate this process. The director will supervise. The QMHP will also supervise and monitor clients and staff by conducting clinical meetings 2 times per month. (V182) The facility is a residential treatment facility for children and adolescents and will recognize age Limitation. If an adolescent has his 18th birthday while receiving treatment in this residential facility, he may continue in the facility for six months or until the end of the state fiscal year, whichever is longer. The facility will submit a waiver with the correct entity ensuring that the facility is in compliance should a client require a longer stay within the facility. This will be monitored by the QMPH, the Director and the	V 179		

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V 179	Continued From page 56 contracted outside professional consultant. Describe your plans to make sure the above happens. The facility will contact and begin utilizing outside professional consultant by October 17th, 2025. The facility will work with the consultant to monitor our progress with meeting the requirements in the plan of protection. The facility will also schedule a staff training as a refresher on Safety, clients rights, confidentiality, Client specific, and Documentation focusing on incident reports and writing incident reports within the required time frame by October 17th." Review on 10/10/25 of the Amended Plan of Protection dated and signed by the CEO/D/L on 10/10/25 revealed : "(V109-V110) The hired consultant will ensure that the Qualified Professional will meet the requirements and demonstrate knowledge and competence by exhibiting the following skills: technical knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills, and clinical skills. The hired consultant will monitor and supervise the Qualified Mental Health Professional and the director. (V182) For the current adult client, in the interim the facility will conduct a weekly placement meeting to determine viable options for the client. While the client remains at the facility, the facility will increase supervision by adding an extra staff member to the shift as one on one for the client. Describe your plans to make sure the above happens. The facility will contact and begin utilizing. The professional consultant must be a licensed professional for example certified in MS (Master of Science), LCAS (Licensed Clinical Addiction Specialist), LCMHC (Licensed Clinical Mental Health Counselor) -QS (Qualified	V 179		

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V 179	Continued From page 57 Supervisor), TFCBT (Trauma Focused Cognitive Behavioral Therapy), CCSI (Clinical Supervisor Intern), C-DBT (Child Dialectical Behavior Therapy). The professional consultant will monitor the facility 2 times a month." This facility served children aged 10-19 years old with diagnoses which included Attention Deficit Hyperactivity Disorder; Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies, Adjustment Disorder, Unspecified Mental Disorder, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. Luca's Hope Haven was opened in January 2025 and all four clients were moved from Sister Facility A without the initial screening assessments or admissions assessments. The facility did not ensure the staff received training on the individual clients treatment needs and goals. There was no documentation that reflects that client needs were ever addressed prior to clients receiving services. The Qualified Professional did not demonstrate the knowledge, skills and abilities to meet the needs of the clients; there were no admission procedures followed, client records were not maintained to include the lack of guardian contact information, there were no current treatment plans, there were no clinical consultations and there was no compliance with state and federal statutes and regulations related to the specific program area. The facility admitted a client who was 18 years and several months old when he was	V 179		

	moved from Sister Facility A to this facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be			

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V 179	Continued From page 58 corrected within 23 days.	V 179		
V 180	27G .1302 Residential Tx - Staff 10A NCAC 27G .1302 STAFF (a) Each facility shall have a director who has a minimum of two years experience in child or adolescent services and who has educational preparation in administration, education, social work, nursing, psychology or a related field. (b) At all times, at least one direct care staff member shall be present with every four children or adolescents. If children or adolescents are cared for in separate buildings, the ratios shall apply to each building. (c) When two or more clients are in the facility, an emergency on-call staff shall be readily available by telephone or page and able to reach the facility within 30 minutes. (d) Psychiatric consultation shall be available as needed for each client. (e) Clinical consultation shall be provided by a qualified mental health professional to each facility at least twice a month. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have one direct care staff present with up to 4 clients and failed to provide clients with clinical consultation by a qualified mental health professional at least twice monthly affecting 3 of 4 clients (Clients #1, #2, and #3). The findings are: Review on 9/18/25 of Client #1's record revealed: -Date of Admission: None documented.	V 180	**V180** The facility will ensure that all clients receiving services will be enrolled with a mental health provider for clinical consultation within 30 days of admission. The QMHP will initiate this process. The director will supervise.The QMHP will also supervise and monitor clients and staff by conducting clinical meetings 2 times per month. The facility will ensure that all staff are present and awake on all shifts. The facility will ensure that the clients will receive therapy sessions by a licensed therapist.	

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V 180	Continued From page 59 -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies -Age: 19 years. Review on 9/18/25 of Client #2's record revealed: -Date of Admission: 2/15/25. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Age: 12 years. Review on 9/18/25 of Client #3's record revealed: -Date of Admission: 2/15/25. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Age: 10 years. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. -Age: 17 years. Finding #1 Observation on 9/17/25 at approximately 9AM-10:30 AM revealed: -Staff left the facility with Client #1 to transport him to work. -Client #1 was wearing jeans and a green colored grocery store t-shirt. Interview on 9/18/25 with the Chief Executive Officer/Director/Licensee (CEO/D/L) revealed: -"[Client #1] works at local grocery store three days a week."	V 180		

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V 180	Continued From page 60 Interview on 9/23/25 with Client #1 revealed: -Was left unsupervised when staff went on grocery runs and picked up the other clients. -"Maybe an hour or two." -At night, "some staff sleep and some are awake for a good chunk of time and then fall asleep ." -"I do believe we can wake them up if we need them." Interview on 9/19/25 with Client #2 revealed: -"Staff sleep when it's bedtime in the front room (bedroom)." Interview on 9/19/25 with Client #3 revealed: -"Only [Client #1] is there (at the facility) on his own." Interview on 9/19/25 with Client #4 revealed: -"Only [Client #1] is unsupervised because he is 19." -"Some staff stay up all night, some will go to sleep." Interviews on 9/23/25 and 10/6/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"[Client #1] is at work." -Client #1 is transported to and from work by staff. -The staff have a room and a bed. -"This is an asleep program." -"They are supposed to get up and check the kids every few hours, making rounds ." -"Staff doesn't chart that they make the round, you (staff) should know that the kids (clients) have to be checked." Interviews on 9/19/25 and 10/6/25 with the Chief Executive Officer/Director/ Licensee (CEO/D/L) revealed:	V 180		

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V 180	Continued From page 61 -"They (clients) should be monitored at all times." -"[Client #1] is in there (other room) and I am here and I get up and look to see what he's doing." -"This is an asleep program." -"They (staff) have to get up multiple times a night...they know how to get up and monitor, which they do." -"There is no form for them to fill out when monitoring during the night." Finding #2 Review on 9/18/25 of Client #1's record revealed: -No evidence of clinical consultations by a Qualified Mental Health Professional (QMHP). Review on 9/18/25 of Client #2's record revealed: -No evidence of clinical consultations by a QMHP. Review on 9/18/25 of Client #3's record revealed: -No evidence of clinical consultations by a QMHP. Interview on 9/19/25 with Client #2 revealed: -No evidence of clinical consultations by a QMHP. Interview on 9/19/25 with Client #3 revealed: -Could not remember if he met with a counselor for therapy. -"[VP/L/QP] sometimes talks with me but she is in her hometown right now, so I haven't seen her in a while." Interview on 9/23/25 with the VP/Licensee/QP revealed: -"[Client #1] has therapy every three months (medication management)." -"[Client #2] has monthly therapy for medications. "Trying to get him a new therapist." -"[Client #3] same thing (trying to get him a therapist), all working together ."	V 180		

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	MHL018-106	A. BUILDING: _____ B. WING _____	10/10/2025

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V 180	Continued From page 62 Interview on 10/6/25 with the CEO/D/L revealed: -"I am responsible for that (setting up clinical consultations)." -"There was a time frame that we weren't able to get therapy due to a waiting list." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 180		
V 182	27G .1303 (B-G) Residential Tx - Operations 10A NCAC 27G .1303 OPERATIONS (b) Family Involvement. Family members or other responsible adults shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) Education. Children and adolescents residing in a residential treatment facility shall receive appropriate educational services, either through a facility-based school, 'home-based' services, or through a day treatment program. Transition to a public school setting shall be part of the treatment plan. (d) Age Limitation. If an adolescent has his 18th birthday while receiving treatment in a residential facility, he may continue in the facility for six months or until the end of the state fiscal year, whichever is longer. (e) Clothing. Each child or adolescent shall have his own clothing and shall have training and help in its selection and care. (f) Personal Belongings. Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Hours of Operation. Each facility shall operate 24 hours per day, at least five days per week, at least 50 weeks per year, excluding legal	V 182		

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V 182	Continued From page 63 holidays. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility admitted a client who was beyond the age limitation of 18 years old affecting 1 of 4 clients (Client #1). The findings are: Review on 9/18/25 of Client #1's record revealed: -Date of Admission: None documented. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Gastroesophageal Reflux Disease, Chronic Constipation, Morbid Obesity, Seasonal Allergies -Age: 19 years. Observation on 9/17/25 and 9/23/25 approximately between 9AM-4PM revealed: -Client #1 was present in the facility. -Client #1 was in the common area and watched videos on his electronic device. -Interview on 10/6/25 with the Department of Social Services (DSS) legal guardian of Client #1 revealed: -He was admitted to the facility on 1/17/25. Interview on 9/18/25, 9/17/25 and 10/6/25 with the Chief Executive Officer/Director/Licensee (CEO/D/L) revealed: -"[Client #1] signed paperwork with [Client #1's DSS Legal Guardian] and is part of the 18-21 (year old) program ." -"I don't have a copy of the 18-21 program	V 182	**V182** The facility is a residential treatment facility for children and adolescents and will recognize age Limitation. If an adolescent has his 18th birthday while receiving treatment in this residential facility, he may continue in the facility for six months or until the end of the state fiscal year, whichever is longer.The facility will ensure full compliance regarding the age limitations for clients admitted to a Level II residential treatment facility serving adolescents.Clients must be under the age of 18 at the time of admission unless they are currently receiving treatment and have turned 18 while in placement. In such cases, the client may remain for no longer than six months or until the end of the state fiscal year, whichever period is longer.For clients approaching the age limit, the QP and Director will initiate transition planning 90 days prior to the 18th birthday, coordinating with the guardian, DSS, or LME/MCO to ensure appropriate referral to an adult or less restrictive setting. This process will be documented in the client's treatment plan and progress notes.The QP will maintain a Client Age Tracking Log for all residents, noting birth dates and anticipated transition dates. This log will be reviewed by the Director to ensure timely transition planning and compliance with age requirements.The Director and QMHP will conduct quarterly admission audits to verify that all clients meet age eligibility criteria at intake and that transition planning is completed for all clients nearing 18 years of age.Through these corrective measures, the facility will ensure that no client is admitted or retained beyond the regulatory age limitations and that all admissions, discharges, and transition plans are conducted in accordance with state law and licensing requirements.	

	from DSS."			

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V 182	Continued From page 64 -Was not aware of the requirement to have a waiver for the rule requirement from the Division of Health Service Regulation and did not request a waiver. -Did not request a waiver from the Division Health Service Regulation. -"The other clients came from another home (sister facility A)... I should have done a discharge from one to the other." - The clients came from both sister facilities when this facility opened. On 9/18/25 a request was made to the CEO/D/L for the "DSS 18-21 year old program." No documentation was provided by the exit date. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 182		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible	V 366		

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V 366	Continued From page 65 for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident	V 366		

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V 366	Continued From page 66 and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 67 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to Level I and Level II incidents as required. The findings are: Review on 9/17/25 of the facility's record revealed: -No documentation of attending to the health and safety needs of any client since the facility has opened. -No documentation on determining the cause of the incident. -No documentation on developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days. -No documentation of developing and implementing corrective measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days. -No documentation of assigning person(s) to be responsible for implementation of the corrections and preventative measures. Review on 9/17/25 of Client #2's record revealed: -Date of Admission: 2/15/25. Age: 12 years old. -Diagnoses: Adjustment Disorder, Unspecified Mental Disorder. -Physician's order dated 12/26/24 included the following: hydroxyzine 25 milligram (mg). -No evidence of consultation with a pharmacist or physician for medication errors.	V 366	**V366** Luca's Hope shall ensure that the staff and facility shall adhere to our written policies governing our response to level I, II or III incidents. Luca's Hope Haven will report evidence that all alleged acts are investigated and will ensure to protect residents from harm while the investigation is in progress. The results of all investigations will be reported to the Department within five working days of the initial notification to the Department. Luca's Hope Haven will ensure that the results of the internal investigation are attached to the report. Luca'sHope III will ensure that all IRIS incidents are reported and submitted within the IRIS system. All Level 2 incidents will be reported within 72 hours of the incident. All Level 3 incidents will be reported within 24 hours of the incidents. Luca's Hope Haven will ensure that any staff involved in an allegation will not be allowed to work effective immediately until the investigation is cleared and deemed unsubstantiated. This shall be monitored by the CEO/Director and QMHP and supervised by the hired Consultant	

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V 366	Continued From page 68 Review on 9/17/25 of Client #2's June 2025 Medication Administration Record (MAR) revealed: -Hydroxyzine 25 mg was not administered on 6/6/25. Review on 9/17/25 of Client #3's record revealed: Date of Admission: 2/15/25. -Age: 10 years. -Diagnoses: ADHD, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. -Physician's orders dated 8/20/25 for Montelukast 4mg. -Physicians orders dated 2/20/25 for Trazadone 50 mg., Sertraline 50mg. -Physician's orders dated 8/15/24 for Loratadine 10mg. -No evidence of consultation with a pharmacist or physician for medication errors. Review on 9/17/25 of Client #3's April 2025- September 2025 MARs revealed: -Montelukast documented as administered in the morning instead of in the evening. -Montelukast 4 mg not initialed as administered 6/30/25, 8/30/25 or 8/31/25. -Trazadone 50 mg at HS not initialed as administered on 6/29/25 or 6/30/25. -Sertraline 50 mg each morning not initialed as administered 6/28/25, 6/29/25 or 6/30/25. -Loratadine not initialed as administered 8/31/25. Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Age: 17 years. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder.	V 366		

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V 366	Continued From page 69 -Physician's orders dated 12/19/24 included the following: Cetirizine HCl 10 milligrams (mg). -Physician's orders dated 1/30/25 included the following: Atomoxetine 40 mg, Trazadone 50 mg. -No evidence of consultation with a pharmacist or physician for medication errors. Review on 9/17/25 of Client #4's April 2025- September 2025 MARs revealed: -Atomoxetine 40 mg 1 tablet twice a day was initialed as being administered once instead of twice per day on 4/2/25-4/4/25 and 4/6/25-4/30/25. -Trazadone 50 mg was initialed as being administered on 6/31/25. Interview on 9/19/25 with Client #3 revealed: -"I tried to grab a knife, but they ran after me and caught me ...I was mad at someone and tried to grab the knife and they got it." -"I felt like nobody cared about me, that's why I wanted to hurt myself but that was a long time ago and I stopped that." Review on 9/18/25 of the safety assessment by the local government agency revealed: -A report was received on 7/21/25 with concerns that Client #3 was threatening to harm himself with safety scissors and was running around with a butter knife. -Chief Executive Officer/Director/Licensee (CEO/D/L) was to ensure that Client #3 wouldn't have access to any sharps. Interview on 9/19/25 with Client #4 revealed: -"[Client #3] was running around." -[Client #3] got upset because him and [Client #2] were playing around, [Client #2] pushed him too hard. [Client #3] said that [Client #2] hated him." -"[Client #3] picked them (scissors) up from the	V 366		

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V 366	Continued From page 70 desk in the office. He was holding them up to his neck and when I seen him, I told him to put the scissors down and he threw them on the floor." Interview on 9/23/25 with Former Staff #2 revealed: -"Heard about someone running around with scissors ." -"I had a thing with one of the clients (Client #4) because he wouldn't eat ...I made him sit at the table and I told him to sit there until it is gone (his food) and if he didn't want to try it to throw it in the trash but he wouldn't get a snack and he dumped the whole plate in the trash." Interview on 9/23/25 with the Vice President/Licensee/Q qualified Professional (VP/L/QP) revealed: -"There was an incident with safety scissors and [Client #3]." -The incident occurred in July 2025. -"[Client #3] was running around with scissors in his hand." -"Had a conversation with [Client #3] about this, did a safety plan that all scissors are put away." -The clients have no access to knives or scissors since that incident. -Haven't had any clients expressing self harm. Interview on 9/18/25 and 10 /6/25 with the CEO/D/L revealed: -"No documented internal facility incident reports to review." -Regarding the incident with safety scissors, "I talked with the [legal guardian of Client #3] about it. -"I missed it (entering it into IRIS)." -"[Former Staff #2] took their games (electronics) and said some rude things to [Client #4], called him a 'punk' or a 'baby'."	V 366		

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V 366	Continued From page 71 -"[Client #4] said that somebody was trying to force him to eat something he didn't like . His name was [Former Staff #2]." -"I told him (Former Staff #2) how dare you force someone to eat something ." -" ...within 72 hours it should be done ....updated into IRIS, and that hasn't always happened (not entering incidents into IRIS)."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any	V 367		

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V 367	Continued From page 72 missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet	V 367		

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V 367	Continued From page 73 the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an incident was reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 9/15/25 of North Carolina Incident Response Improvement System (IRIS) from 1/1/25-9/15/25 revealed: -No documentation of level II or III IRIS report was completed for the facility. Finding #1 Review on 9/18/25 of the safety assessment by the local government agency revealed: -A report was received on 7/21/25 with concerns that Client #3 was threatening to harm himself with safety scissors and was running around with	V 367	**V367** Luca's Hope shall ensure that the staff and facility shall report all level II and level III incidents to the LME/MCO responsible for the catchment area where services are provided within 72 hours of becoming aware of the Level 2 incident and within 24 hours for a level 3 incident. The facility will ensure strict compliance by implementing clear procedures and oversight for timely incident reporting to the LME/MCO within the required 72-hour timeframe.The Incident Reporting Policy has been reviewed with all staff to increase their awareness of expectation that all Level II and Level III incidents, including deaths, must be entered into the Incident Response Improvement System (IRIS) and submitted to the LME/MCO within 72 hours of the facility becoming aware of the event.The QP or Director on duty will be responsible for initiating the incident report immediately upon discovery. The Director will verify completion, accuracy, and submission within the 72-hour window.Through this corrective plan, the facility will maintain timely, accurate, and verifiable reporting of all incidents ensuring transparency, client safety, and regulatory adherence.	

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V 367	Continued From page 74 a butter knife. -Chief Executive Officer/Director/Licensee (CEO/D/L) was to ensure that Client #3 wouldn't have access to any sharps. Review on 9/17/25 of Client #3's record revealed: Date of Admission: 2/15/25. -Age: 10 years. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Reactive Attachment Disorder. Interview on 9/19/25 with Client #3 revealed: -"I tried to grab a knife, but they ran after me and caught me ...I was mad at someone and tried to grab the knife and they got it." -"I felt like nobody cared about me, that's why I wanted to hurt myself but that was a long time ago and I stopped that." Interview on 9/19/25 with Client #4 revealed: -"[Client #3] was running around." -[Client #3] got upset because him and [Client #2] were playing around, [Client #2] pushed him too hard. [Client #3] said that [Client #2] hated him." -"[Client #3] picked them (scissors) up from the desk in the office. He was holding them up to his neck and when I seen him, I told him to put the scissors down and he threw them on the floor." Interview on 9/23/25 with Former Staff #2 revealed: -"Heard about someone running around with scissors." Interview on 9/23/25 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"There was an incident with safety scissors and	V 367		

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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-106	A. BUILDING: _____ B. WING _____	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 75 [Client #3]." -The incident occurred in July 2025. -"[Client #3] was running around with scissors in his hand." -"Had a conversation with [Client #3] about this, did a safety plan that all scissors are put away." -The clients have no access to knives or scissors since that incident. Interview on 9/18/25 and 10/6/25 with the Chief Executive Officer/Director/Licensee (CEO/D/L) revealed: -"No documented internal facility incident reports to review. -" ...within 72 hours it should be done...updated into IRIS, and that hasn't always happened." -"I know that we should do a lot better on what is being done in house reporting." -"It's just been a lot and it's going to get better." -"There will be a sheet to show incidents." -Regarding the incident with safety scissors, "I talked with the [legal guardian of Client #3] about it. -"I missed it (entering it into IRIS)." Finding #2 Review on 9/18/25 of Client #4's record revealed: -Date of Admission: 1/31/25. -Age: 17 years. -Diagnosis: ADHD Predominantly Hyperactive Presentation, Adjustment Disorder with Depressed Mood, Unspecified Trauma and Stressor-Related Disorder. Interview on 9/23/25 with Former Staff #2 revealed: -"I had a thing with one of the clients (Client #4) because he wouldn't eat...I made him sit at the table and I told him to sit there until it is gone (his food) and if he didn't want to try it to throw it in the	V 367		

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V 367	Continued From page 76 trash but he wouldn't get a snack and he dumped the whole plate in the trash." Interview on 9/18/25 and 10 /6/25 with the CEO/D/L revealed: -"[Former Staff #2] took their games (electronics) and said some rude things to [Client #4], called him a 'punk' or a 'baby'." -"[Client #4] said that somebody was trying to force him to eat something he didn't like. His name was [Former Staff #2]." -"I told him (Former Staff #2) how dare you force someone to eat something ." -" ...within 72 hours it should be done...updated into IRIS, and that hasn't always happened (not entering incidents into IRIS)."	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.	V 536		

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V 536	Continued From page 77 (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).	V 536		

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V 536	Continued From page 78 (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at	V 536		

	preventing,			

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V 536	Continued From page 79 reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility	V 536	V536 The facility will ensure full compliance by establishing and enforcing a structured, documented, and competency-based training and refresher program for all staff on the use of alternatives to restrictive interventions. The facility staff are currently fully trained in EBPI(Evidence Based Protective Interventions)The Qualified Professional Completed training and became certified and an EBPI instructor for the facility. Moving forward the facility will ensure that trainers and coaches meet all qualifications required including passing instructor-level certification and completing refresher instructor training every two years.All staff will be automatically scheduled for annual EBPI refresher training each calendar year. Training sessions will be documented and maintained by the Director and or QMHP and reviewed quarterly to verify ongoing compliance. The Director and QMHP will conduct quarterly training record audits to confirm completion, accuracy, and retention of all EBPI training documentation.Any lapse in annual training will result in immediate removal from direct care duties until the required training is completed. The policy will be reinforced during new hire orientation and monthly staff meetings to ensure continuous awareness and adherence.Through this corrective plan, the facility will maintain full compliance, ensuring that all staff consistently demonstrate competency in preventing, reducing, and eliminating the need for restrictive interventions, thereby promoting a safe, therapeutic, and person-centered environment.	