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 ______	R 02/16/2026

NAME OF PROVIDER OR SUPPLIER: **LUCA'S HOPE HAVEN**

STREET ADDRESS, CITY, STATE, ZIP CODE: **4675 HICKORY LINCOLNTON HWY, NEWTON, NC 28658**

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DHSR-MH Licensure Sect

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V 000	INITIAL COMMENTS A follow up survey was completed on February 16, 2026. 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 3 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Clients will be identified using the letter of the facility and a numerical identifier. It could not be determined if the previously cited deficiency 10A NCAC 27G .0201 Governing Body Policies (V105) was corrected during this survey due to insufficient evidence to determine compliance.	V 000	(V109) The facility has engaged a contracted consultant to monitor and aide the facility with getting in compliance with state requirements for the level program. The facility hired a new QMHP effective immediately. The QMHP has the following qualification **(MS, LCAS, LCMHC-QS, TFCBT, CCSI, C-DBT Board Certified Clinical Hypnotherapist)**The QMHP will provide direct clinical oversight and guidance of the program and will be physically present at the facility on a regular basis to ensure direct supervision of services for clients and staff. The QMHP will review all clinical responsibilities including admission assessments, treatment plans, documentation requirements, and supervision of staff to ensure services are provided within the scope of practice and meet the needs of the population served. The QMHP will review all active and newly admitted consumer records to ensure proper clinical oversight is in place and that consumers are safe and receiving appropriate services.The facility will continue recruitment efforts to hire additional QMHP staff to ensure adequate clinical coverage and ongoing onsite clinical oversight of the program. The Director will monitor that QMHP responsibilities including oversight of assessments, treatment planning, and clinical consultation requirements are completed in accordance with 10A NCAC 27G standards. The facility will conduct monthly Quality Assurance reviews to ensure continued compliance with Qualified Professional competency requirements and program oversight.	March 18th, 2026
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileges 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	V 109		

3/9/26

	professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge;			

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V 109	Continued From page 1	V 109		
	(2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (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 required by the population served. The findings are: Review on 2/11/26 and 2/12/26 of the VP/L/QP's record revealed: -Date of Hire: 8/7/23. -Job description included: -"Essential Functions/Responsibilities 1. Overall responsibility for the			

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V 109	Continued From page 2 interdisciplinary team process with each individual served, guardian, and/or advocate. Work in conjunction with these individuals, other professionals, consultants and staff in developing, implementing, documenting, monitoring and adjusting the plan of care and related programs ... 2. Ensure admission and discharge procedures are followed according to policy ... 3. ...Conduct reviews of clinical documentation to ensure that it meets the requirements for the service being provided ...Ensure, through regular audits, that accurate and timely documentation is occurring and that client records are maintained according to policy. Prepare and submit required or requested reports, documents, assessments, evaluations and paperwork. Review and sign off on clinical documentation as required ... 5. Provide direction and supervision to staff in regards to carrying out programs, services and supports related to participants needs. Monitor performance and implementation of these responsibilities by being present when day-to-day activities; routines and rhythms are taking place, on all shifts and by unannounced visits ... 6. Ensure staff are appropriately trained regarding plans and related programs and demonstrate and understanding of specific plan components (including but not limited to all privileging requirements as outlined by area programs). Assist in the design and presentation of facility wide training. 7. Participate in meeting and training as required. Maintain cortication in all agency, state and federal training requirements. 8. Demonstrate knowledge of and comply with all agency policies and procedures, as well as state and federal statues and regulations	V 109		

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related to specific program areas.
9. ...Participate in on-call coverage ..."

Refer to V111 for evidence that the VP/L/QP failed to ensure that admission assessments were completed prior to the delivery of services.

Refer to V112 for evidence the VP/L/QP failed to develop and implement the treatment plans with current strategies to address clients' needs in partnership with the legally responsible person.

Refer to V180 for evidence that the VP/L/QP failed to ensure clients received clinical
consultation by a qualified mental health professional at least twice monthly.

Interview on 2/10/26 with Client #1 revealed:
-He could not remember the last time he saw the VP/L/QP, "She is sick though. I did video with her before, but can't remember when."

Interview on 2/10/26 with Client #2 revealed:
-"We pick [VP/L/QP] up at the airport every time she comes back (from a foreign country). She just had leg surgery, so I see her on a video every month."

Interview on 2/10/26 with Client #4
revealed: -[VP/L/QP] is coming back
(from a foreign
country) in March (2026). I see her on the video. She ...asks us (clients) how it's been here (at the facility) and wants to know what is going on."

Interview on 2/12/26 with Staff #1 revealed:
-"[VP/L/QP] is in [foreign country], but she takes turns. She is home (in foreign country)

	two weeks and then here in North Carolina for two weeks." -She "last saw her (VP/L/QP) at Christmas (2025) and the first of the New Year (2026)."			

V 109	Continued From page 4 Interview on 2/11/26 with the VP/L/QP revealed: -"We put out an ad to hire 2 new QPs ...I will be stepping down from that role to make sure there is a QP that can be there (at the facility) all the time. That's what we will be doing." -"I see the clients virtually." -She departed the United States in December 2025 to return to the foreign country and planned to return to the United States on March 15, 2026. Interview on 2/11/26 with the Chief Executive Officer/Director/Licensee revealed: -"[VP/L/QP] ...will be back (from foreign country) in exactly 2 weeks (2/25/26) ...She did virtual visits. She is still doing virtual ..." -"Everything is still the same (since the last survey completed 10/10/25) as far as QP services." -The facility was "going to hire 2 different QP's ...had some great responses. The snow held us back; we couldn't bring anybody in ..." -"The plan is she (VP/L/QP) won't be the QP any longer. We need the QP to be more involved with staff and clients ...Our QP needs to be onsite more ..." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	V 109		
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	V 110	**(V110)**The facility has engaged a Qualified Mental Health Professional (QMHP) who has assumed clinical oversight of the program effective immediately. The QMHP will provide direct supervision of paraprofessional staff, including the Director, to ensure that duties performed by paraprofessionals remain within their scope of practice and are appropriately supervised. The QMHP will review staff responsibilities related to admissions, documentation, treatment planning coordination, and clinical service oversight to ensure compliance with 10A NCAC 27G requirements. The consultant will also review all active consumer records to ensure that services, assessments, and treatment plans are appropriately supervised by the QMHP and that consumers are safe.The Director will work under the supervision of the QMHP regarding admission procedures, treatment planning coordination, and service documentation to ensure compliance with regulatory requirements. The facility will conduct monthly Quality Assurance reviews to verify that paraprofessional duties are appropriately supervised and that documentation and services are being implemented according to regulatory standards..	March 18th, 2026

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V 110	Continued From page 5 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 2 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 2/11/26 and 2/12/26 of the CEO/D/L's record revealed:	V 110		

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V 110	Continued From page 6 -Date of Hire: 8/12/08. -Job description included: -"Primary Responsibility: ...compliance with safety regulations ...Work in conjunction with other professionals, consultants and staff in developing, implementing, documenting, monitoring and adjusting the plan of care and related programs ...Ensure admission and discharge procedures are followed according to policy." Refer to V111 for evidence that the CEO/D/L failed to ensure that admission assessments were completed prior to the delivery of services. Refer to V112 for evidence the CEO/D/L failed to develop and implement the treatment plans with current strategies to address clients' needs in partnership with the legally responsible person. Refer to V180 for evidence that the CEO/D/L failed to ensure clients received clinical consultation by a qualified mental health professional at least twice monthly. Interview on 2/11/26 and 2/13/26 with the CEO/D/L revealed: -Admission assessments were to be completed by "me, I'm the Director. They (admission applicants) actually come to me first, then they go to [Vice President/Licensee/Qualified Professional (VP/L/QP)]." -A template was used for treatment plans, "I guess it didn't get changed". -She had been informed by the agency providing clinical consultation that documentation of the clients' sessions would be accessible, however, she was unable to	V 110		

	obtain any of the records. "I inquired about getting notes (therapy notes) and [Therapist] said we should be able to get on site			

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V 110	Continued From page 7 (website), but I did, and I don't see anything that is giving me the opportunity to view or print out anything. All I can do is schedule (therapy appointments) ...I explained we were a licensed agency, and they (therapy providers) told me there would be all these things to have access to and they (clients) have their sessions, but there's nothing here to show you (Division of Health Service Regulation Surveyors) that." -She had not understood that all previously cited deficiencies were required to be fully corrected and in compliance by the specified deadline. "I thought the deadline was just for us (Licensee) to have something to work on, and I didn't know we had to have something already in place." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	V 110	**(V111)**The facility has hired a Qualified Mental Health Professional (QMHP) who has assumed responsibility for clinical oversight effective immediately. The QMHP will review all active consumer records to ensure that an admission assessment has been completed for each client and that assessments include the required elements as outlined in **10A NCAC 27G .0205.** Any missing or incomplete admission assessments will be completed immediately by the QMHP and placed in the client record. The QMHP will verify that no services are delivered to newly admitted clients until an admission assessment has been completed. The facility will require that all admission assessments be completed by the QMHP prior to the delivery of services in accordance with facility policy and **10A NCAC 27G .0205.** The QMHP will be responsible for ensuring that each assessment includes the client's presenting problems, needs and strengths, relevant history, and appropriate diagnosis or provisional diagnosis.The facility will ensure that all consumers currently receiving services have appropriate assessments and documentation to ensure that services are aligned with their needs and that consumers are safe.The facility will implement an admission documentation checklist to ensure that assessments are completed prior to service delivery and properly maintained in the client record. The Director will coordinate admissions; however, the QMHP will be responsible for completing or directly overseeing admission assessments and approving documentation prior to service delivery. The facility will include an admission assessment review in the monthly Quality Assurance process to ensure continued compliance with **10A NCAC 27G .0205.**	March 18th, 2026
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;	V 111		

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V 111	Continued From page 8 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed, according to governing body policy, prior to the delivery of services for 1 of 3 audited clients (#4). The findings are: Review on 2/12/26 of the facility's undated "Policy 203: Admissions Assessments" revealed: -"All admissions assessments will be done by the qualified professional/Director ...Assessments will be done within the time frame of 24 - 48 hours ..." Review on 2/10/26 of Client #4's record revealed: -Date of Admission: 10/25/25. -Age: 13 years. -Diagnoses: Unspecified Trauma and Stressor Related Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder.	V 111		

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V 111	Continued From page 9 -No documentation of an admission screening. -No documentation of an admission assessment until 1/28/26. Interview on 2/11/26 with the Vice President/Licensee/Qualified Professional (VP/L/QP) revealed: -"[Client #4] moving from one place (Sister Facility A) to another (Luca's Hope Haven), we did the full screening process." Interview on 2/10/26 and 2/13/26 with the Chief Executive Officer/Director/Licensee (CEO/D/L) revealed: -"I still have the same three clients as before (previous Division of Health Service Regulation Survey completed 10/10/25) and [Client #4] was transferred from [Sister Facility A]." -She was responsible for the completion of initial admission assessments, and the VP/L/QP would review and sign off on them. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	V 111	**(V112)** The facility has a Qualified Mental Health Professional (QMHP) who has assumed responsibility for clinical oversight effective immediately. The QMHP has reviewed all active client treatment plans and Child and Family Team (CFT) documentation to ensure that plans are based on the assessment and reflect the current needs of each client. Any treatment plans that contain incorrect information, incomplete strategies, template errors, or outdated goals will be corrected immediately by the QMHP. The facility will discontinue the use of generic templates that may result in incorrect client information and will implement a treatment plan review process to ensure plans accurately reflect each client. The QMHP will ensure that treatment plans include individualized goals and strategies that directly address each client's identified needs and behaviors. The QMHP will also ensure that CFT meetings are properly documented, including identification of team members present, signatures or documented participation, meeting duration, and scheduling of the next meeting. The facility will require that all treatment plans be developed and maintained by the QMHP in partnership with the client and legally responsible person in accordance with 10A NCAC 27G .0205. The QMHP will ensure that treatment plans include measurable outcomes, individualized strategies, staff responsible for implementation, and appropriate evaluation methods. The QMHP will also ensure that the legally responsible person or guardian is involved in treatment planning and that participation and consent are properly documented in the client record. The facility will review all client records to ensure that services currently being delivered are aligned with updated treatment plans and that consumers are safe.The facility will implement a treatment plan review checklist and will include treatment plan documentation in the monthly Quality Assurance review process to ensure continued compliance with 10A NCAC 27G .0205.	March 18th, 2026
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE 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	V 112		

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V 112	Continued From page 10 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 goals and strategies to address clients' needs in partnership with the legally responsible person for 3 of 3 audited clients (#1, #2, and #4). The findings are: Review on 2/12/26 of the facility's undated "Policy 203: Admissions Assessments" revealed: -" ...Clients progress will be reviewed and monitored during all scheduled CFT (Child Family Team) meetings that will include the legal guardian, client and other members on clients team regarding his service and care ...All parties on the clients team during the monthly meetings will include a written agreement with signatures of	V 112		

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V 112	Continued From page 11 the legal guardian, all clinical staff ..." Review on 2/10/26 of Client #1's record revealed: -Date of Admission: 2/15/25. -Age: 10 years. -Diagnoses: Post Traumatic Stress Disorder; Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Insomnia. Review on 2/11/26 and 2/12/26 of Client #1's CFT meeting notes for 11/2/25-2/11/26 revealed: -CFT meeting notes were documented for 11/4/25, 12/9/25, and 1/13/26. -None of the notes identified which members of the client's treatment team were present at the meetings. -The section titled "Signatures of Team Members Present" was left blank on all notes except for the Vice President/Licensee/Qualified Professional's (VP/L/QP's) signature. -The sections titled "Duration," "Date of Next Scheduled Meeting," and "Location of Next Scheduled Meeting" were left blank on all notes. -CFT note dated 12/9/25 revealed "The client has expressed hope and interest in the possibility of being allowed have contact with his sister, which was discussed as a motivating factor for continued positive behavior and emotional regulation ...Recommendation ...support emotional processing related to family relationships ...Monitor emotional responses related to family contact discussions." Review on 2/12/26 of Client #1's treatment plan dated 1/13/26 revealed: -Daily Life: " ...[Client #1] talks a lot about his sister and being able to see her." -No goals or strategies to address Client #1's desire to develop a relationship with his sister, or Client #1's processing of emotions related to	V 112		

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V 112	Continued From page 12 family contacts. -Goal Support/Interventions included: -"Guardian: Participate in all scheduled CFT meetings ..." -"MCO (Managed Care Organization) will participate in all scheduled CFT meetings ..." -Facility staff will "utilize behavior management system ...Staff, in conjunction with therapist, will implement a modified plan where [Client #1] can achieve daily rewards based safe and positive behaviors ..." -The MCO's support and intervention strategy for each identified goal incorrectly referenced the name of Client #3 instead of Client #1. Review on 2/10/26 of Client #2's record revealed: -Date of Admission: 2/15/25. -Age: 13 years. -Diagnoses: Insomnia; Adjustment Disorder with Disturbance of Conduct. Review on 2/11/26 and 2/12/26 of Client #2's CFT meeting notes for 11/2/25-2/11/26 revealed: -CFT meeting notes were documented for 11/19/25, 12/19/25, and 1/16/26. -None of the notes identified which members of the client's treatment team were present at the meetings. -The section titled "Signatures of Team Members Present" was left blank on all notes except for the VP/L/QP's signature. -The sections titled "Duration," "Date of Next Scheduled Meeting," and "Location of Next Scheduled Meeting" were left blank on all notes. Review on 2/12/26 of Client #2's treatment plan dated 10/6/25 and updated on 11/19/25, 12/9/25 and 1/16/26 revealed: -Goal Support/Interventions included:	V 112		

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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 112	Continued From page 13 -"Level II Group Type will provide rules, rewards, and consequences ...Facilitate monthly CFTs ..." -"[Department of Social Services (DSS) legal guardian] will participate in monthly CFTs ..." -"[Client #2] will ...attend monthly CFTs ..." -"MCO will participate in all scheduled CFT meetings ..." Review on 2/10/26 of Client #4's record revealed: -Date of Admission: 10/25/25. -Age: 13 years. -Diagnoses: Unspecified Trauma and Stressor Related Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder. -Legal Guardian: Client #4's Mother. Review on 2/11/26 and 2/12/26 of Client #4's CFT meeting notes for 11/2/25-2/11/26 revealed: -CFT meeting notes were documented for 11/20/25, 12/19/25, and 1/14/26. -None of the notes identified which members of the client's treatment team were present at the meetings. -The section titled "Signatures of Team Members Present" was left blank on all notes except for the VP/L/QP's signature. -The sections titled "Duration," "Date of Next Scheduled Meeting," and "Location of Next Scheduled Meeting" were left blank on all notes. Review on 2/12/26 of Client #4's treatment plan dated 6/25/25 and updated on 7/29/25, 8/20/25, 9/12/25, 10/21/25, 11/20/25, 12/19/25 and 1/14/26 revealed: -"Safety and Security ...[Client #4] does utilize his coping skills so that he does not leave home (facility) when upset and does his best	V 112		

	to remain safe by not leaving, going AWOL (Absent Without			

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V 112	Continued From page 14 Leave)." -No goals or intervention strategies to prevent Client #4 from going AWOL. -Goal Support/Interventions included: -Facility staff would provide a "point-level system." -Guardian will participate in scheduled meetings. -The "Individual and/or Natural Support Actions" for each identified goal incorrectly listed DSS as the legal guardian rather than Client #4's Mother. -One of the support and intervention strategies documented under each goal incorrectly referenced the name of a former client (FC #A5) from Sister Facility A instead of Client #4. Interview on 2/10/26 with Client #1 revealed: -Asked if the Division of Health Service Regulation surveyors would speak with his DSS legal guardian about his desire to see his sister who he had not seen in 3 years. Interviews on 2/10/26 with Client #2 and #4 revealed: -They had no information about their treatment plan goals. Interview on 2/11/26 with the VP/L/QP revealed: -The CFT meeting notes should have been signed by all members in attendance. -"When we had them (CFT meetings) in the past, we had them on site (at the facility) and I was given permission to sign for them (team members) and we make it a practice that we can go ahead and sign for them." -"So far, we haven't had to update any goals" on any of the clients' treatment plans. -When Client #4 transferred from Sister Facility A	V 112		

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V 112	Continued From page 15 to Luca's Hope Haven, his treatment plan "transferred the same." Interview on 2/13/26 with the Chief Executive Officer/Director/Licensee (CEO/D/L) revealed: -FC #A5's name was on the treatment plans because "he was in the same home as [Client #4]. We have a new template that we use, and she (VP/L/QP) uses a template, and I guess it just didn't get changed." -"[FC #A5] is one of the kids (clients) from the other facility (Sister Facility A). He was discharged (from Sister Facility A) ...either August 28th (2025) or something." -There was no documentation of the "reward system" referred to in the clients' treatment plans. "Nothing is written ...They (clients) know the rules ...they know they have to make their bed and pick their clothes up off the floor in order to earn for the week. No tracking of it ...We (staff) don't necessarily keep up with it because they (clients) know what to do." This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	V 112	(V113) The facility has hired a Qualified Mental Health Professional (QMHP) who has assumed responsibility for clinical oversight effective immediately. The QMHP has initiated a review of all active client records to ensure that documentation of services provided and client progress toward identified outcomes is present in each record. Any missing service documentation or progress notes will be completed immediately by the appropriate staff and reviewed by the QMHP to ensure accuracy and completeness. The facility will implement a standardized documentation process to ensure that services provided to each client are documented consistently and that progress toward treatment plan outcomes is recorded in the client record. The facility will ensure that each client record contains the required documentation including assessments, treatment plans, service documentation, and progress toward outcomes to support the services being provided. The QMHP and Director will verify that all client records are complete and that documentation reflects the services currently being delivered to ensure the safety of the consumers.The QMHP will review documentation regularly to ensure that it reflects the implementation of the treatment plan and progress toward identified goals. The facility will implement a client record checklist to verify that each record contains all required components in accordance with 10A NCAC 27G .0206. The Director and QMHP will conduct monthly record audits to ensure documentation is completed and maintained appropriately. Documentation compliance will also be included as part of the facility's ongoing Quality Assurance process to ensure continued compliance with client record requirements.	March 18th, 2026
V 113	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; (C) date of birth; (D) race, gender and marital status; (E) admission date;	V 113		

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V 113	Continued From page 16 (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete client records for 3 of	V 113		

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V 113	Continued From page 17 3 audited clients (#1, #2, and #4). The findings are: Review on 2/10/26 of Client #1's record revealed: -Date of Admission: 2/15/25. -Age: 10 years. -Diagnoses: Post Traumatic Stress Disorder; Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Insomnia. -No documentation of services that were provided. -No documentation of client progress toward outcomes. Review on 2/10/26 of Client #2's record revealed: -Date of Admission: 2/15/25. -Age: 13 years. -Diagnoses: Insomnia; Adjustment Disorder with Disturbance of Conduct. -No documentation of services that were provided. -No documentation of client progress toward outcomes. Review on 2/10/26 of Client #4's record revealed: -Date of Admission: 10/25/25. -Age: 13 years. -Diagnoses: Unspecified Trauma and Stressor Related Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder. -No documentation of services that were provided. -No documentation of client progress toward outcomes. Interview on 2/11/26 with the Chief Executive Officer/Director/Licensee revealed: -She was responsible for maintaining client records with the assistance of facility staff. -Documentation "has been more consistent"	V 113		

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V 113	Continued From page 18 since the previous Divsion of Health Service Regulation survey completed 10/10/25. -She planned to implement an electronic records system at the facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 113	**(V179)**The facility will ensure that services are delivered within a structured therapeutic environment consistent with the residential treatment level II program requirements. The facility will implement a structured clinical oversight process to ensure compliance with all residential treatment program requirements. The QMHP has assumed responsibility for direct clinical oversight of the program and will ensure that services are provided in accordance with the needs of the children and adolescents served. The QMHP will immediately review all active client records to ensure that admission assessments, treatment plans, service documentation, and clinical consultation requirements are completed and maintained in accordance with **10A NCAC 27G requirements.** The facility will ensure that treatment plans are individualized, updated as needed, and developed in collaboration with the client and legally responsible person through documented Child and Family Team (CFT) meetings. The facility will ensure that all services provided to clients support skill development including self-control, communication, social skills, and recreational skills consistent with residential treatment program expectations. The QMHP will coordinate with therapists, guardians, schools, and other agencies involved in the client's care to ensure services are delivered through a coordinated system of care. The QMHP will ensure that treatment plans are individualized, based on the client's assessment, and developed in partnership with the client and legally responsible person. The facility will verify that all clients are receiving appropriate therapeutic services, including regular clinical consultation and coordinated services within the client's system of care. The facility will review all program operations to ensure that services are supporting each client's development of communication, social, emotional regulation, and behavioral skills necessary for successful functioning within the home, school, and community. The Director and QMHP will conduct routine reviews of client records and program documentation to ensure compliance with assessment, treatment planning, and documentation requirements. The facility will include program oversight, documentation compliance, and service coordination in the monthly Quality Assurance review process to ensure continued compliance with residential treatment program requirements.	March 18th, 2026
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 19 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide 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 affecting 3 of 3 audited clients (#1, #2 and #4). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals & 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 required by the population served. Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review and interview, 1 of 2 audited 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 an	V 179		

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V 179	Continued From page 20 assessment was completed, according to governing body policy, prior to the delivery of services for 1 of 3 audited clients (#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 goals and strategies to address clients' needs in partnership with the legally responsible person for 3 of 3 audited clients (#1, #2, and #4). Cross Reference: 10A NCAC 27G .1302 Staff (V180). Based on record review and interview, the facility failed to ensure that clinical consultation was provided by a qualified mental health professional (QMHP) at least twice a month for 3 of 3 audited clients (#1, #2, and #4). Review on 2/13/26 of the plan of protection completed and signed by the CEO/D/L on 2/13/26 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? (V109) The facility will engage the contracted consultant to work directly with the current QMHP (VP/L/QP) to ensure the QMHP has the appropriate knowledge, training, and competencies to fully perform the duties of the role. The consultant will monitor and review all clinical responsibilities and supervision expectations with the QMHP records to ensure proper clinical oversight is in place and that consumers are safe. (V110) The facility will immediately review all paraprofessional personnel files to verify required training and competency documentation. The facility will use the direct supervision of the consultant to ensure paraprofessionals are	V 179		

PRINTED: 02/26/2026
FORM APPROVED

Division of Health Service Regulation

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V 179	Continued From page 21 functioning within their scope of duties. The Director (CEO/D/L) will monitor to ensure that all of the practices are being followed and completed. (V111/112) The QMHP, Director and consultant will immediately ensure that an assessment is completed on all newly enrolled clients within 30 days of enrollment. The QMHP, Director and consultant will review all active consumer assessments and Person-Centered Plans to ensure they are current, complete, and signed. The QMHP and Director will review and correct any missing or incomplete documentation. The QMHP and Director will ensure that each consumer has a current assessment supporting the service plan. All assessments will be completed within 30 days of being enrolled into the program. The QMHP and Director will assess all consumers to ensure services are aligned with identified needs and that no consumer is at risk. The QMHP will ensure that therapy appointment summaries for each client are being completed by the therapist and provided to the facility in reference to every appointment. (V180) The QMHP will immediately ensure that all contracted clinical consultations (therapy services) provided to consumers include a written summary of each session. The facility will request and obtain documentation from the licensed therapist outlining the date of service, general focus of the session, and any recommendations impacting treatment or supervision. The facility will place all received summaries in the consumer's record to ensure continuity of care. The facility will review active records to confirm	V 179		

	consumers receiving therapy have documentation on file. The facility will assess all consumers to ensure safety and appropriate coordination of care. Describe your plans to make sure the above			

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V 179	Continued From page 22 happens. The facility under the supervision of the consultant will implement standardized credential verification procedures to ensure all Qualified Professionals and paraprofessionals meet required competencies prior to hire and throughout employment. The facility will hire additional QMHP staff to ensure adequate clinical oversight and supervision within 30 days. The facility will conduct quarterly personnel file audits to verify ongoing compliance with licensure, education, and training requirements. The facility will implement structured supervision logs and require documented monthly reviews by the Qualified Professional under the supervision of the consultant. The Director will establish a tracking system to monitor assessment, service plan, and documentation due dates to ensure timely updates are being completed by the QMHP. The facility will require written summaries from contracted therapists following each clinical consultation and maintain a tracking log to verify receipt. The facility under the supervision of the consultant will conduct monthly Quality Assurance reviews to monitor documentation, staffing, and service alignment." Review on 2/16/26 of the 1st addendum to the plan of protection completed and signed by the CEO/D/L on 2/15/26 revealed: -"(V109) ...The current QMHP will continue to perform duties under the direct supervision of the consultant in the interim until additional QMHP staff is hired ..." Review on 2/16/26 of the 2nd addendum to the plan of protection completed and signed by the CEO/D/L on 2/16/26 revealed: -" ...(V110) ...The consultant will monitor to ensure that all of these practices are being	V 179		

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V 179	Continued From page 23 followed and completed ...The facility will utilize the consultant immediately whom will oversee all operations of the program ..." The facility served children and adolescents. Clients #1, #2, and #4 were between 10 and 13 years of age and had documented mental health diagnoses including, but not limited to Post Traumatic Stress Disorder, Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder with Disturbance of Conduct, Unspecified Trauma and Stressor Related Disorder, and Oppositional Defiant Disorder who required structured therapeutic services and ongoing clinical oversight. The CEO/D/L and the VP/L/QP did not demonstrate competency by not ensuring compliance with admission assessment, treatment planning, documentation, and clinical consultation requirements. Professional oversight was limited, as the VP/L/QP resided outside of the United States for extended periods of time and primarily provided virtual services, with no evidence of adequate on-site supervision or alternative oversight structures. Client #4's assessment was not completed until 90 days after his admission to the facility. Treatment plans for clients #1, #2, and #4 were not individualized, contained inaccurate information, and did not reflect collaboration with legally responsible persons. Child and Family Team (CFT) meeting documentation was incomplete, lacked required signatures, and omitted required details. Clinical consultation by a qualified mental health professional was not documented as occurring at least twice monthly for clients #1, #2, or #4 and no therapy session summaries were maintained. This deficiency constitutes a continuing Type A1 rule violation originally cited for serious neglect for	V 179		

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V 179	Continued From page 24 failure to correct within 23 days.	V 179	**(V180)** The facility will ensure that the QMHP immediately reviews all active client records to verify that clinical consultation is being provided to each client at least twice monthly as required by **10A NCAC 27G .1302.** The QMHP will coordinate with the licensed therapist providing clinical consultation services to ensure that appointments are scheduled consistently and that services are provided to each client. The facility will immediately obtain written summaries for each clinical consultation session including the date of service, general focus of the session, and any recommendations impacting treatment or supervision. The QMHP will review all documentation received from the therapist and ensure it is placed in the client record. The facility will review all current client records to ensure that each client is receiving appropriate therapeutic services and that services are documented to ensure the safety of the consumers.The QMHP will review clinical consultation documentation to ensure that recommendations are incorporated into the client's treatment plan and implemented by staff when appropriate. The facility will maintain a clinical consultation tracking log to ensure that required services are provided and documented for each client. The Director and QMHP will include clinical consultation documentation in the facility's ongoing Quality Assurance review process to ensure continued compliance with residential treatment program requirements.	March 18th, 2026
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 record review and interview, the facility failed to ensure that clinical consultation was provided by a qualified mental health professional (QMHP) at least twice a month for 3 of 3 audited clients (#1, #2, and #4). The findings are: Review on 2/10/26 of Client #1's record revealed: -Date of Admission: 2/15/25. -Age: 10 years.	V 180		

	-Diagnoses: Post Traumatic Stress Disorder;			

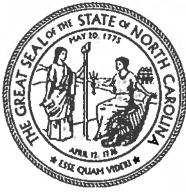
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL018-106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED R 02/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

V 180	Continued From page 25 Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Insomnia. -No documentation of clinical consultation by a QMHP provided at least twice monthly. Review on 2/10/26 of Client #2's record revealed: -Date of Admission: 2/15/25. -Age: 13 years. -Diagnoses: Insomnia; Adjustment Disorder with Disturbance of Conduct. -No documentation of clinical consultation by a QMHP provided at least twice monthly. Review on 2/10/26 of Client #4's record revealed: -Date of Admission: 10/25/25. -Age: 13 years. -Diagnoses: Unspecified Trauma and Stressor Related Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder. -No documentation of clinical consultation by a QMHP provided at least twice monthly. Interview on 2/10/26 with Client #1 revealed: -He wasn't sure if he received clinical consultation, "I'm not sure about therapy, I don't know what that means." Interview on 2/10/26 with Client #2 revealed: -"I don't remember great. I don't remember if I see a therapist." Interview on 2/10/26 with Client #4 revealed: -"I think I see a therapist at the house (facility) every Saturday at 11:00 (am) for at least 1 hour. I don't know their name." Interview on 2/11/26 with the Chief Executive Officer/Director/Licensee revealed: -She did not have any documentation of clinical consultations for any of the clients, "We don't	V 180		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 180	Continued From page 26 have the notes, we don't have the appointment summaries ...that's something we are going to work on and change ...they (clients) have missed (clinical consultations) the last few weeks. He (therapist) got sick ...that's why I called today and asked for a new, different therapist." Interview on 2/11/26 with the Vice President/Licensee/Qualified Professional revealed: -Clients had been receiving clinical consultations since October 2025. -All clinical consultations had been conducted virtually. -The facility had not received any feedback, or documentation for any of the clinical consultation sessions. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	V 180		



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA CERTIFIED MAIL

March 3, 2026

Ms. Valarie Stanback, CEO/Director
Ms. Keosha Walden
Luca's Hope, L.L.C.
PO Box 442
Sherrills Ford, NC 28673

Re: Follow Up Survey completed February 16, 2026
Luca's Hope Haven, 4675 Hickory Lincolnton Hwy, Newton, NC 28658
MHL # 018-106
E-mail Address: valariestanback@yahoo.com

Dear Ms. Stanback and Ms. Walden:

Thank you for the cooperation and courtesy extended during the follow up survey completed February 16, 2026.

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

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

Type of Deficiencies Found

- Type A1 rule violations are ***continued*** for 10A NCAC 27G .1301 (V179) Cross Reference 10A NCAC 27G .0203 Competencies of Qualified Professionals (V109); 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110); 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111); 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112); 10A NCAC 27G .1302 Staff (V180).
- Re-cited standard level deficiency.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the

survey, which is March 18, 2026.

Time Frame for Compliance – Continued Type A1

- *You must submit in writing, via mail, the date by which the deficiency will be corrected. The second follow up visit will be scheduled based on a revisit request and supporting compliance documentation presented during an informal or formal hearing.* When the second follow-up visit is completed and the facility is determined to be in compliance with the previously cited deficiency, you will be notified by mail of the total penalty amount owed. However, if it is determined the facility is still out of compliance, administrative penalties will continue to accrue until such time the deficient practice is corrected.

As a result of this survey, a Notice of Revocation is being issued. You are still responsible for making the required corrections of the noted deficiencies within the above required timeframes. If a follow-up survey is requested and completed, failure to make the corrections within the required timeframes may result in further penalties and/or administrative actions.

What to include in the Plan of Correction

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

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

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

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Eileen Moreno, Team Leader at 336-247-0107.

Sincerely,

Sally Thayer
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Maria Smith

Maria Smith
Nurse Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
dhhs@vayahealth.com
Karen Harrington, Director, Catawba County DSS
Michael Blake, Administrative Supervisor