		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		MHL007-055	B. WING		03/2	8/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODE	D ACRES #3		RRY ROAD	7000		
240.15	CUIMMA DV CTA		TON, NC 27		ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-s	V 000			
	A complaint survey was completed on March 28, 2018. The complaint was substantiated (intake #NC00132792). A deficiency was cited					
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
V 364	G.S. 122C- 62 Add Facilities	litional Rights in 24 Hour	V 364			
	Facilities.  (a) In addition to the 122C-51 through G who is receiving tre 24-hour facility keep (1) Send and receivances to writing massistance when not (2) Contact and cound at no cost to the physicians, and privide velopmental disapprofessionals of his (3) Contact and countere is a client advothere is a client advothere.	ve sealed mail and have aterial, postage, and staff ecessary; insult with, at his own expense e facility, legal counsel, private rate mental health, bilities, or substance abuse choice; and insult with a client advocate if ocate.  In this subsection may not be cility and each adult client may as at all reasonable times. In ded in subsections (e) and (h) in adult client who is receiving atton in a 24-hour facility at all int to:  I ve confidential telephone are calls shall be paid for by the of making the call or made				

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

TITLE (X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL007-055	B. WING		03/2	8/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
WOODE	D ACRES #3	3680 CHE	RRY ROAD			
1100521			TON, NC 27	7889		I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 364	hours daily, two hour p.m.; however visition over therapies; (3) Communicate a supervision with indupon the consent of (4) Make visits outsunless:  a. Commitment produced the result of the clied violent crime, included assault with a dead respondent was four insanity or incapable b. The client was committed to the factor commitment to a commitment of the commitm	for a period of at least six urs of which shall be after 6:00 ng shall not take precedence and meet under appropriate lividuals of his own choice of the individuals; side the custody of the facility roceedings were initiated as ant's being charged with a ding a crime involving an ly weapon, and the und not guilty by reason of e of proceeding; voluntarily admitted or cility while under order of precetional facility of the extrection of the Department of ing held to determine capacity at to G.S. 15A-1002; expressly authorize visits do by the existence of the ed by this subdivision; daily and have access to ment for physical exercise ek; libited by law, keep and use and possessions, unless the to determine capacity to of G.S. 15A-1002; eligious worship; da reasonable sum of his	V 364			
	prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
	MHL007-055	B. WING		03/2	8/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
WOODED AODEO #0	3680 CHE	RRY ROAD			
WOODED ACRES #3	WASHING	TON, NC 27	7889		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
122C-51 through G.S who is receiving treat 24-hour facility has the proper adult supervise recognition of the minimidividual, the minor supportunities to enable emotionally, intellectual imma 24-hour facility shall particularly structure, supervisions the rights given to the The facility shall also reasonable efforts to client receives treatmedult clients unless the minor client dictate on Each minor client when the habilitation from a 24 (1) Communicate and guardian or the agen custody of him; (2) Contact and consor that of his legally recost to the facility, legally respections, private madisabilities, or substate his or his legally respectives a client advolute is a client advolute the facility of the rights specified in restricted by the facility may exercise these respectives.	e rights enumerated in G.S. S. 122C-57 and G.S. S. 122C-61, each minor client tment or habilitation in a ne right to have access to sion and guidance. In nor's status as a developing shall be provided ole him to mature physically, ually, socially, and of the physical, emotional, aturity of the minor, the provide appropriate n and control consistent with e minor pursuant to this Part. In where practical, make ensure that each minor nent apart and separate from the treatment needs of the otherwise.  In is receiving treatment or industry in the industry in the right to one consult with his parents or account with a this own expense responsible person and at no gal counsel, private the ental health, developmental ance abuse professionals, of consible person's choice; and sult with a client advocate, if	V 364			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED		
MHL007-055		B. WING		03/28/2018			
	DD0//DED 05 0//25/		DDE00 0:=:::	2747F 7ID 00DF			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WOODE	D ACRES #3		RRY ROAD				
		WASHING	STON, NC 27	7889			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE	
17.0		,	17.0	DEFICIENCY)			
1/ 264	Continued From no		V 364				
V 364	Continued From pa	ge 3	V 364				
	treatment or habilita	ation in a 24-hour facility has					
	the right to:						
		ive telephone calls. All long					
		be paid for by the client at the					
	_	call or made collect to the					
	receiving party;						
		ve mail and have access to					
	when necessary;	ostage, and staff assistance					
		ate supervision, receive					
	(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00						
	p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;						
		l education and vocational					
	training in accordan	ice with federal and State law;					
		daily and participate in play,					
		sical exercise on a regular					
	basis in accordance						
		ibited by law, keep and use					
		nd possessions under					
		sion, unless the client is being apacity to proceed pursuant to					
	G.S. 15A-1002;	apacity to proceed pursuant to					
	(7) Participate in re	eligious worship:					
		individual storage space for					
		personal belongings;					
		and spend a reasonable sum					
	of his own money; a						
		s license, unless otherwise					
		er 20 of the General Statutes.					
		rated in subsections (b) or (d)					
		be limited or restricted except					
		fessional responsible for the					
		lient's treatment or habilitation					
		ment shall be placed in the ndicates the detailed reason					
	for the restriction. The restriction shall be						

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL007-055	B. WING		03/2	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODE	D ACDEC #2	3680 CHE	RRY ROAD			
WOODE	D ACRES #3	WASHING	TON, NC 27	7889		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 4	V 364			
	habilitation needs. A period not to excee each restriction shad qualified profession at which time the reach evaluation of documented in the rights may be renew statement entered the client's record the client's record the renewal of the restriction of rights who has not be in each instance of of a restriction of rights the client shall, use notified of the reach in the case of a nadult client, the legal be notified of each or renewal of a restreason for it. Notificindividual or legally	A restriction is effective for a d 30 days. An evaluation of all be conducted by the all at least every seven days, estriction may be removed. A restriction shall be client's record. Restrictions on wed only by a written by the qualified professional in the tastes the reason for the iction. In the case of an adult been adjudicated incompetent, an initial restriction or renewal afts, an individual designated upon the consent of the client, striction and of the reason for minor client or an incompetent ally responsible person shall instance of an initial restriction riction of rights and of the eation of the designated responsible person shall be ng in the client's record.				
	facility failed to ensu	views and interviews, the ure that restriction of clients' property was documented and for two of four audited				
	Review on 03/28/18 of client #5's record revealed: - 31 year old male Admission date of 01/26/17 Diagnoses of Mild to Moderate Intellectual Developmental Disability and Major Depression.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL007-055	B. WING		03/2	8/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODED ACRES #3		RRY ROAD TON, NC 27	7889		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BY BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
client #5's personal cell Review on 03/28/18 of orevealed: - 27 year old male Admission date of 01/0 - Diagnosis of Schizoaff Disorder-Depressed Typ - No required document client #6's personal cell Interview on 03/28/18 cl - He had resided at the - He was his own guard own cell phone He had to turn his pers at 9pm He had been accused 1am and he now had to - Staff also required clie - He did not like staff to  Interview on 03/28/18 cl - He had resided at the - His mother was his gu - He had 2 personal cell his phones at 9pm He did not have phone internet.  Interview on 03/28/18 si	tation of the restriction of phone at 9pm daily.  client #6's record  06/14. fective pe. tation of the restriction of phone at 9pm daily.  lient #5 stated: facility for 1 year. lian. He purchased his sonal cell phone in to staff of talking on his phone at turn his phone in. ent #6 to turn in his phone. keep his personal phone.  lient #6 stated: facility for 5 or 6 years. liardian. I phones. He had to turn in the service but used the staff #1 stated: ity overnight Monday thru required to turn in their 9pm. sent inappropriate text	V 364			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL007-055	B. WING		03/2	8/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	·	
WOODE	D ACRES #3		TON, NC 2	7889		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 364	Interview on 03/28/stated: - She had worked a one year She was not awar. #5 and #6's persona She was schedule 04/05/18 and would Interview on 03/28/stated: - Client #5 and #6 h meet two female cli The clients used the sneaking out of the - The clients would night and made it dinext morning The facility had cliphones in at 9pm. The school the clicell phones in the construction.	18 the Qualified Professional at the facility for approximately the the facility had taken client al cell phones at 9pm daily. The did to visit the facility on the review the identified issue. The Facility Administrator and left the facility at night to the rest from a sister facility. Their cell phones to coordinate facility. The clients received their the school was completed. The clients received their the school was completed. The facility needed to follow the the restricting the use of	V 364			

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