PRINTED: 04/10/2019
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
	MHL043-104	A. BUILDING: _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODARD'S HOME	1709 ATKINS ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An Annual Survey was completed on 03/28/19. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living/Alternative Family Living	V 000	Corrective Action: Staff will ensure they review the chards of all clients For 10A NCAC 27G.0205 Assessment and Treatment/Habilitation for yearly Treatment plan. Administrator will be responsible and rechecking of all chards for yearly Treatment Plans. Client #1 PCP will be implemented on May 1, 2019.	5/1/19
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 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.	V 112		

RECEIVED
By DHSR - Mental Health Lic. & Cert. Section at 10:15 am, Apr 18, 2019

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenora Woodard	Administrator	4/18/19

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a treatment plan developed based on the assessment and inclusive of outcomes, strategies, staff responsible and basis for evaluation or assessment of outcome achievement for one of two audited clients (#1). The findings are: Review on 03/22/19 of client #1's record revealed: -Admitted: 11/01/13 -Diagnoses which included schizophrenia, mental retardation and seizure disorder Review on 03/22/19 of document labeled "Individualized Treatment Plan of Care" dated 04/13/18 for client #1 revealed: -"Services Provided: Medication Management -Target outcomes: maintain mental health care to manage/decrease symptoms of his illness, keep part-time employment, continue living in the group home -Projected date of outcome achievement (6-12 months): 4/13/19 -Individual Signature: [client #1's name written in cursive] -Printed name: [client #1's name typed and hand written]Licensed Clinical Social Worker] -Date: 4/13/18 -Provider Signature [signature]" with credentials for Licensed Clinical Social Worker (LCSW) -Printed name of Provider with LCSW credentials During interview on 03/22/19, the Licensee reported: - 2 clients resided at the group home	V 112		

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V 112	Continued From page 2 -She utilized a management company for oversight purposes -The management company did not provide services to client #1 -Client #1's treatment plan was completed by a Social Worker at a program -In 2018, the Social Worker indicated her agency changed their treatment plan model and would not provide any additional information. During interview on 03/25/19, the Management Company's Qualified Professional reported: -The second client in the group home was a client of their company, not client #1. -Oversight provided was only for the second client at the group home -She would not have reviewed any documentation or records for client #1 -Her agency had recently changed ownership. A follow up with provider services verified no changes had been made and client #1 did not receive services. During interview on 03/27/19, client #1's LCSW reported: -Client #1 attended a clinic in which he was seen by a physician. Goals were established and reviewed by the physician/Psychiatrist. She worked at the clinic and provided assistance with paperwork for those in need. -She had never met client #1. -The treatment plan provided to the group home was a medical treatment plan not a person centered plan nor did it address residential goals and needs. "Those types of plans were normally completed by residential qualified professionals."	V 112		

COMMUNITY INNOVATIONS
Person-Centered Services

Fax Transmittal Form

TO: Division of Health Service Regulation
Name: India Vaughn-Rhodes
Organization Name/Dept:
CC:
Phone number: 919-855-3795
Fax number: 919-715-8078

Urgent ()
For Review ()
Please Comment
Please Reply

FROM: Community Innovations
Senora Woodard
Woodard's Home
Phone: (919) 303-5377

Fax: (919) 303-5380

Date sent: 4-18-19
Time sent:
Number of pages including cover page: 4 pgs
RE: Corrective Action Plan
MHL # 043-104