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
	MHL007-056	A. BUILDING: _____ B. WING _____ DHSR	R 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODED ACRES #4	3650 CHERRY ROAD WASHINGTON, NC 27889

APR 3 0 2019
Lic. & Cert. Section

(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 A complaint and follow-up survey was completed on April 4, 2019. The complaint was substantiated (intake #NC00150120). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	V112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 Implemented April 15, 2019.	
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	All residents plans will have documented diagnosis and recommendations from a doctor included in their treatment plan. Any new orders from a doctor or therapist will be completed in a revision to the plan. QP will complete plans with in 30 days of admission and revisions as needed. All plans will be updated annually regardless of no revisions. QP will monitor residents for behavior changes and any changes to doctors orders.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Princess Henderson

TITLE: Director

(X6) DATE: 4-24-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting one of three audited clients (#3). The findings are: Review on 04/04/19 of client #3's record revealed: - 38 year old male. - Admission date of 12/26/18. - Diagnoses of Mild Intellectual Developmental Disability, Pre-Diabetes and Schizoaffective Disorder. - Treatment plan dated 12/27/18. - No strategies to address client #3's Pre-Diabetes to include blood sugar checks and diabetic diet. Review on 04/04/19 of a signed FL-2 for client #3 dated 12/13/18 revealed: - Diagnosis of Pre-Diabetes. - Medication- Metformin (treats Diabetes) XR 24 tablet 500 milligrams - take with breakfast. Review on 04/04/19 of client #3's signed Physician Assistant orders dated 01/10/19 revealed: - "ADA (American Diabetes Association) Diet" - Accu-check meter with strips (used to check blood sugar values). Interview on 04/04/19 client #3 stated: - He had recently been diagnoses with diabetes. - Staff checked his blood sugar values daily. Interview on 04/04/19 the Qualified Professional stated: - He would include information regarding client	V 112	on a regular basis. ex: if a resident is having behaviors will monitor daily until behavior is resolved. dis orders will be monitored as a resident goes to dis appointments: weekly, mthly bi-weekly etc: QP will report changes to administrator so they are met.	

Division of Health Service Regulation

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V 112	Continued From page 2 #3's diabetes in the treatment plan. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 112	V114 27G .0207 Emergency Plans and Supplies 10 A NCAC 27G .0207 Emergency Plans & Supplies.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 04/04/19 of facility records from January 2019 thru April 4, 2019 revealed the following: Fire Drills - 03/06/19 1st shift at 4:15pm. Disaster Drills	V 114	Implemented April 10th, 2019 QP will monitor & complete routine fire/disaster drills quarterly. Drills will be completed 1 per shift for sleep and awake drills. All staff will be trained and kept informed of drills and how to implement the drills. QP will monitor drill times to ensure residents are exiting the building in a timely manner in case of a real emergency QP will keep drills recorded & documented & have a copy	

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V 114	Continued From page 3 - No documented drills. Interview on 04/04/19 the Qualified Professional and Administrator stated: - They understood the frequency fire and disaster drills should be completed at the facility. - They would ensure fire and disaster drills were completed as required. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 114	of the drills in the Homes also. V118 27G .0209 (c) Medication Requirements 10A NCAC 27G .0209 Medication requirements Implemented April 10, 2019	
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; (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	V 118	All medication administrations will be given and documented as ordered by a doctor at the time noted to be given. Documentation must be signed at time of administration all blood pressures & blood sugar readings must be recorded on MAR each day as ordered. If a resident is out of the facility, it must be documented "Out" out of facility not left	

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V 118	Continued From page 4 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, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three clients (#2, #3 and #4). The findings are: Finding #1: Review on 04/04/19 of client #2's record revealed: - 32 year old male. - Admission date of 01/26/17. - Diagnoses of Mild Intellectual Developmental Disability (IDD) and Recurrent Major Depression. Review on 04/04/19 of a signed FL-2 for client #2 dated 01/17/19 revealed: - Check blood pressure once daily. - Celexa (antidepressant) 20 milligrams (mg) once daily. Review on 04/04/19 of a signed physician order dated 02/25/19 revealed: - Temazepam (treats insomnia) 15mg - take one tablet at bedtime. Review on 04/04/19 of client #2's March 2019 MAR revealed: - No blood pressure documented from 03/19/19 thru 03/25/19.	V 118	blank. All medication changes must be changed on MAR w/ a current effective date. AP will monitor all changes + ensure that documentation supporting change is transcribed correctly and kept in orders. AP will monitor books medications, + documentation no less than weekly. This will ensure all B/P + B/S readings are recorded as ordered and all medication is being administered correctly AP will report any errors to administrator. Any staff that continues to make errors will recieve disciplinary	

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V 118	Continued From page 5 - Celexa - no initials for 03/02/19 and 03/24/19. - Temazepam - no initials 03/24/19 and "No refills" handwritten from 03/28/19 thru 03/31/19. Finding #2: Review on 04/04/19 of client #3's record revealed: - 38 year old male. - Admission date of 12/26/18. - Diagnoses of Mild IDD, Pre-Diabetes and Schizoaffective Disorder. Review on 04/04/19 of a signed FL-2 for client #3 dated 12/13/18 revealed: - Diagnosis of Pre-Diabetes. - Medication- Metformin (treats Diabetes) XR 24 tablet 500 milligrams - take with breakfast. Review on 04/04/19 of client #3's signed Physician Assistant orders dated 01/10/19 revealed: - Accu-check meter with strips (used to check blood sugar values) use as directed. Review on 04/04/19 of client #3's signed physician orders dated 01/10/19 revealed: - Haldol Decanoate (anti-psychotic) 100mg - inject every 4 weeks. - Cogentin (treats Parkinson's disease symptoms) 2mg - take one tablet twice daily. Review on 04/04/19 of client #3's March 2019 MAR revealed the following blanks: - Haldol Decanoate - no staff initials the medication was administered. - Cogentin - 03/25/19 at 8am. - 03/21/19 thru 03/25/19 - no documented blood sugar values. Interview on 04/04/19 client #3 stated:	V 118	actions will be required to take further medication training until management is satisfied of the staff competency. 2) staff continues to make errors, staff will be relieved of position.	

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V 118	Continued From page 6 - He received his medication daily. - Staff check his blood sugar values once daily. Finding #3: Review on 04/04/19 of client #4's record revealed: - 55 year old male. - Admission date of 10/21/87. - Moderate IDD, Urology Problems, Anxiety Disorder, Chronic Urinary Tract Infection and Attention Deficit Hyperactivity Disorder. Review on 04/04/19 of a signed FL-2 dated 01/28/19 revealed the following medication order: - Ativan (antianxiety) 0.5mg - take twice daily. Review on 04/04/19 of client #4's March 2019 MAR revealed the following blanks: - Ativan 03/27/19 thru 03/30/19 at 8pm. Interview on 04/04/19 the Administrator stated: - She had recently addressed medication issues with the facility staff. - She was aware the MARs were to be kept current. - She would continue to monitor staff and medication administration concerns. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 118		

PCP (UPDATE/REVISION)

*(For use **ONLY** if a new service or a new goal is added to the PCP during the plan year.)*

Name: [redacted]	DOB: [redacted]	Medicaid ID: [redacted]	Record #: n/a
Update/Revision Date	4 /8/2019		

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals information, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

"I want a safe place to live, take my medications like I should, get my GED, and live on my own"

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

"I am almost there"

[redacted]s just beginning on goals and is on the first stags of ADLS and GED completion. [redacted]has had no real experiences in taking care of himself and allows others to exploit him and use him for their gain. [redacted]has a history of legal problems and medication non-compliance. He currently was denied by his Father to go live with him because he smokes.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: [redacted]s a pre-diabetic and has been put on a special diet by his primary care doctor. He has been getting a 2000 cal. diet sense coming to Wooded Acres. The continued diet will help improve his Blood Sugar and over-all health.

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
"I don't think I am a diabetic but will follow diet as doc said" Doctor recommends a 2000 Cal. Diet (ADA) to reduce carbohydrate intake to balance blood sugar levels.	Quang Wooded Acres Staff Primary care doctor	Daily 24/7 365 days a year As needed

HOW (Support/Intervention)
Wooded Acres will monitor [redacted]diet and ensure he is getting recommended amounts. [redacted]will limit his soda intake and work to quit smoking as this adds to his weight gain and not good for balanced sugar levels. Primary care doctor will assist as needed for contro and compliance.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
4/8/2020	4/8/2019	O	This goal will remain in effect until released by Primary care doctor
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**

HOW (Support/Intervention)

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**

Name: [redacted] DOB: [redacted] Medicaid ID: [redacted] Record #: n/a

UPDATE/REVISION PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- x I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- x I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- ☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes x No ☐

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: [redacted] _____ (Print Name) Date: / /

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ (Print Name) Date: / /

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: Russ Hass BS, NCCPSS, DSW, QP (Person responsible for the PCP) Wooded Acres Guest Home Inc. (Name of Case Management Agency) Date: 4/8/2019

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- ☐ Met with the Child and Family Team - Date: / /
- ☐ OR Child and Family Team meeting scheduled for - Date: / /
- ☐ OR Assigned a TASC Care Manager - Date: / /
- ☐ AND conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- ☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ (Person responsible for the PCP) _____ (Print Name) Date: / /

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s). ☑ Yes ☐ No
- The licensed professional who signs this service order has had direct contact with the individual. ☑ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment.

Signature: [redacted] PA-C Dennis Czuchra License #: 101721 Date: 4/8/19

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- OR recommended for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- ☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: / /

(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: / /

Other Team Member (Name/Relationship): _____ Date: / /

Shift-1 M-fri @ 11:30 am
fri - M @ 9:30
11:30 Shift 2.

-FIRE AND DISASTER REHEARSAL SCHEDULE

Name of Home: House #4

Address: 3650 Cherry Rd Washington

1. Date of Rehearsal: 3/6/19 Time of Rehearsal: 4:15 pm Shift: 1st – 2nd – 3rd (Circle One)

Type of Drill Conducted: Fire

Person in Charge: Russ Hass QP

Other Staff Members Present: Mitchell manager

Time for Total Evacuation: 1:10 Sec

Brief Description of What Was Involved: Set off Alarm Had 5 Evacuate with House Manger. 1 participated sleeping and left Behind.

2. Date of Rehearsal: 4/12/19 Time of Rehearsal: 11:30 am Shift: ~~1st – 2nd~~ change – 3rd (Circle One)

Type of Drill Conducted: Fire

Person in Charge: Russ Hass

Other Staff Members Present: Mami, N. Tchell

Time for Total Evacuation: 2 min

Brief Description of What Was Involved: Alarm Seconded all were Evacuated Safely.

3. Date of Rehearsal: 4-13-19 Time of Rehearsal: 10:30 pm Shift: 1st – 2nd – 3rd (Circle One)

Type of Drill Conducted: firedrill

Person in Charge: Robyn Peele time of evacuation 2min 10 sec.

Sounded alarm - Staff immediately went + woke residents up + exited building

M-fri @ 11:30 shift 1
fri - M @ 9:30 am shift 2

-FIRE AND DISASTER REHEARSAL SCHEDULE

Name of Home: Wooded Acres house #4

Address: 3650 Cherry Rd. Thurs

1. Date of Rehearsal: 4-11-17 Time of Rehearsal: 5:30am Shift: (1st) – 2nd – 3rd (Circle One)

Type of Drill Conducted: Deep Sleep Fire Drill

Person in Charge: Mamie Harrell

Other Staff Members Present: none

Time for Total Evacuation: 41 sec.

Brief Description of What Was Involved: Staff set off alarm and yelled fire clients went to cross across the Road to the fence

2. Date of Rehearsal: Sunday 4-14-19 Time of Rehearsal: 3:30pm Shift: 1st – (2nd) – 3rd (Circle One)

Type of Drill Conducted: fire drill awake

Person in Charge: Robyn Peele

Other Staff Members Present:

Time for Total Evacuation: 1min 50 sec

Brief Description of What Was Involved: Staff was cooking + alarm went off - residents left building promptly.

3. Date of Rehearsal: 4-14-19 Time of Rehearsal: _____ Shift: 1st – (2nd) – 3rd (Circle One)

Type of Drill Conducted: Tornado drill

Person in Charge: Robyn Peele.

Residents got into closets (bent down) + covered heads w/ pillows

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

April 9, 2019

Ms. Priscillia Hardison, Director
Wooded Acres Guest Home, Inc.
3706 Cherry Road
Washington, NC 27889

Re: Complaint and Follow-up Survey completed April 4, 2019 Wooded Acres #4, 3650 Cherry Road, Washington, NC 27889
MHL # 007-056
E-mail Address: wjones@woodedacres.org
Intake #NC00150120

Dear Ms. Hardison:

Thank you for the cooperation and courtesy extended during the complaint and follow-up survey completed April 4, 2019. The complaint was substantiated.

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

- Re-cited standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is May 4, 2019.

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.*** MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718 www.ncdhhs.gov/dhsr
• TEL: 919-855-3795 • FAX: 919-715-8078

April 9, 2019
Ms. Hardison Wooded Acres
Guest Home, Inc.

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 Wendy Boone, Team Leader at (252)568-2744.

Sincerely,

Keith Hughes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
File