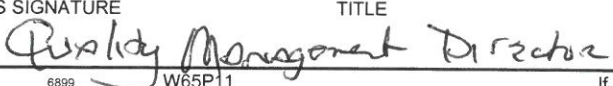


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043-048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER: **WOODHAVEN FAMILY CARE FACILITY**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **436 WEST ROAD CAMERON, NC 28326**

(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 October 3, 2019. 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		
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 reviews and interviews, the facility failed to conduct fire drills under conditions that simulate emergencies at least quarterly and repeated for each shift. The findings are:  Record review on 10/3/19 of the facility's fire drill log revealed the following: -9/14/19-1st shift. -8/13/19- 2nd shift. -8/5/19- 1st shift.	V 114	The facility will ensure evacuation drills are conducted at least quarterly under varied conditions for each shift in the home.  The Residential Manager will in-service the staff in the home on the evacuation process and schedule.  The evacuation schedule will be posted for staff review. The Residential Manager will track all evacuations on a monthly basis to ensure compliance.  The Quality Management Director will review all evacuation drills on a monthly basis to ensure continued compliance.	12/3/19        12/3/19        12/3/19

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: **Quality Management Director** (X6) DATE: **10/19/19**

STATE FORM

6899 W65P11

If continuation sheet 1 of 7

DHSR-Mental Health

OCT 29 2019

Lic. & Cert. Section

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043-048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN FAMILY CARE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>436 WEST ROAD CAMERON, NC 28326</b>		
(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 114	Continued From page 1  -7/24/19- 2nd shift. -7/15/19- 2nd shift. -5/11/19- 1st shift. -4/12/1- 2nd shift. -4/1/19- 1st shift. -3/29/19- 2nd shift. -3/18/19-1st shift. -2/12/19- 2nd shift. -2/8/19- 1st shift. -1/15/19- 2nd shift. -1/11/19- 1st shift. -1/8/19- 3rd shift. -1/1/19- 2nd shift. -12/28/18- 2nd shift. -12/8/18- 1st shift. -12/1/19- 1st shift. -11/15/18- 2nd shift. -11/4/18- 1st shift. -10/28/19- 2nd shift. -10/14/18- 2nd shift. -10/7/18- 1st shift. -Facility operated under three shifts. -There were no fire drills conducted for 3rd shift for the fourth quarter of 2018. -There were no fire drills conducted for 3rd shift for the second quarter of 2019. -There were no fire drills conducted for 3rd shift for the third quarter of 2019.  Interview on 10/3/19 with the Qualified Professional (QP) revealed: -Facility had created a calendar with suggested drills to be performed. -Shift staff were supposed to follow fire drills schedule. -She was aware that former third shift staff had not conducted fire drills during his shift. -She confirmed staff failed to conduct drills under conditions that simulate fire emergencies under each shift on each quarter.	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043-048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN FAMILY CARE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>436 WEST ROAD CAMERON, NC 28326</b>		
(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 118	<p>27G .0209 (C) Medication Requirements</p> <p>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 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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to ensure the medication administration</p>	V 118	<p>The facility will ensure that the medication administration system is accurate and documentation on the MAR reflect administration of all medications in compliance with the physician's orders.</p> <p>The Residential Manager will in-service all staff in the home on documentation on the MAR.</p> <p>The Residential manager will monitor in the home and complete an observation of the medication pass and review the MAR- at least twice weekly in the home.</p> <p>The Quality Management Director will review the MAR at least weekly to ensure continued compliance.</p>	<p>12/3/19</p> <p>12/3/19</p> <p>12/3/19</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043-048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2019</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>436 WEST ROAD CAMERON, NC 28326</b>
---	---

(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 118	<p>Continued From page 3</p> <p>record (MAR) was current for one of three audited clients (#3). The findings are:</p> <p>Review on 10/3/19 of Client #3's record revealed: - Admission date of 7/24/18. -Diagnoses of Autism Disorder; Schizoaffective Disorder; Mild Intellectual Disabilities. .</p> <p>Review on 10/3/19 of Client #3's physician's orders dated the following: -Order dated 7/16/19: -Olanzapine 5 mg- Take one tablet in the morning, one tablet during dinner, 2 tablets in the evening. -Melatonin 5 mg- Take two tablets in the evening. -Benztropine mes 0.5 mg- Take one tablet twice daily. -Refresh Tears Lubricant Eye Drop- Place a drop into both eyes in the evening. -Vimpat 100 mg- Take one tablet twice daily. -Order dated 8/28/19: -Rexulti 0.5 mg- Take one tablet twice daily.</p> <p>Observation on 10/3/19 at 11:30 pm of Client #3's medications revealed the following was available: -Olanzapine 5 mg. -Melatonin 5 mg. -Benztropine mes 0.5 mg. -Refresh Tears Lubricant Eye Drop. -Vimpat 100 mg. -Rexulti 0.5 mg.</p> <p>Review on 10/3/19 of Client #3's MAR for October 2019 revealed blanks on the following dates: - Olanzapine 5 mg- 10/1 at 5:00 pm and 8:00 pm, 10/2 at 5:00 pm and 8:00 pm. -Melatonin 5 mg- 10/1, 10/2. -Benztropine mes 0.5 mg- 10/1 at 8:00 pm, 10/2 at 8:00 pm.</p>	V 118		
-------	---	-------	--	--



I t i n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL043-048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ :	(X3) DATE SURVEY COMPLETED  10/03/2019
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN FAMILY CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 436 WEST ROAD CAMERON, NC 28326		
(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 118	Continued From page 4  -Refresh Tears Lubricant Eye Drop- 10/1, 10/2 -Vimpat 100 mg- 10/1 at 8:00 pm, 10/2 at 8:00 pm. -Rexulti 0.5 mg- 10/1 at 8:00 pm, 10/2 at 8:00 pm.  Interview on 10/3/19 with the Qualified Professional (QP) revealed: -She confirmed that client #3's medication was available at the house. -She acknowledged that staff failed to mark appropriately the medication as administered on 10/1 and 10/2. -She counted current medications and assured that the medications for 10/1 and 10/2 had been given to Client #3. -She acknowledged that the medication administration record (MAR) was not kept current for client #3.	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are:  Observation on 10/3/19 at 11:30 AM of the	V 736		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2019</b>
	<b>MHL043-048</b>	B. WING: _____	

NAME OF PROVIDER OR SUPPLIER <b>WOODHAVEN FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>436 WEST ROAD CAMERON, NC 28326</b>
---	---

(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 736	Continued From page 6  area revealed: -New panels still being worked on top of drywalls. -Holes on the walls under the television and under the windows had been covered by pieces of wood  Interview on 10/3/19 with the Qualified Professional revealed: -Agency was responsible for doing maintenance for the home. -Home was currently in midst of renovation. - Home was getting new windows and wall panels. - Bathrooms were also going to be renovated. - Clients were going to be away from the home on the weekend so that work could continue. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.	V 736		



**Victor**  
**& ASSOCIATES INC.**

*Provider of MH/DD/SA Services*

---

October, 22 2019

Mr. Edgar Garrido, MSW  
Facility Compliance Consultant I  
N.C. Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

DHSR-Mental Health

OCT 29 2019

Lic. & Cert. Section

Re: MHL Annual Survey completed 10/3/2019  
Woodhaven Family Care Facility  
436 West Road, Cameron, NC 28326  
MHL#043-048

Dear Mr. Garrido:

See attached hard copy of the plan of correction (POC) for the Woodhaven Family Care Facility visit. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact me directly. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James A. Harris  
Director, Quality Management