STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL007054	A. BUILDING: _____ B. WING _____	R 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODED ACRES #2	3644 CHERRY ROAD WASHINGTON, NC 27889

(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 and follow up survey was completed on November 12, 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	V112 27G .0205 (C-D) Assessment/Treatment/Habilatation Plan Implemented Dec 29, 2019 AP will ensure all Plans are completed w/in 30 days of admission. AP will hold team meeting to gather information regarding resident + discuss what is important to the resident. What does the resident expect from the facility what it is that we as provider can do to help the resident be successful	
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		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Priscilla Hardison — Owner — 1-30-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL007054	A. BUILDING: _____ B. WING _____	R 11/12/2019

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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 a treatment plan within 30 days of admission for one of three audited clients (#6). The findings are: Review on 11/08/19 of client #6's record revealed: - 46 year old female. - Admission date of 09/25/19. - Diagnoses of Mild Intellectual Developmental Disability, Paranoid Schizophrenia, Renal Insufficiency, Hypothyroidism and Diabetes Mellitus. - No treatment plan. Review on 11/08/19 of a pre-admission screening for client #6 dated 09/11/19 revealed: - Plan: Medication Management, Appointments and Safe Living Environment. Interview on 11/08/19 client #6 stated: - She was recently admitted to the facility. - She had not been taking her medication correctly while living at home. Interview on 11/08/19 the Administrator stated: - Client #6 was recently admitted to the facility. - The facility was in the process of creating a treatment plan for client #6. - She understood a treatment plan was required to be developed within 30 days of admission to the facility.	V 112	QP will complete the plan w/ information gathered. Plan will be sent to doctor to review and agree w/ plan or advise of any changes. facility administrator will follow-up with the QP to ensure plan is completed & implemented w/in 30 days of admission.	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration:	V 118	V118 Medication Requirements facility administrator will follow-up w/providing	

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	MHL007054	A. BUILDING: _____ B. WING _____	R 11/12/2019

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V 118	Continued From page 2 (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. 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 affecting one of three audited clients (#2). The findings are: Review on 11/06/19 of client #2's record revealed:	V 118	doctors regarding medication change. Any orders that may be misleading or not clear will need clarifications from the doctor. If 2 orders are received within 24 hrs and they do not support each other administrator will immediately reach out to doctor Once clarification is received, it must be sent to pharmacy to be changed or removed from residents MAR. Documentation of all efforts made to resolve this issue must be	

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V 118	Continued From page 3 - 66 year old female. - Admission date of 07/29/16. - Diagnoses of Major Depression, Mild Intellectual Developmental Disability, Parkinson's Disease, Edema, Restless Leg Syndrome and Anxiety Disorder. Review on 11/06/19 of client #2's signed physician order dated 09/16/19 revealed: - Forteo (treats Osteoporosis) pen - give 0.08 milliliters everyday. Review on 11/06/19 of client #2's October 2019 thru November 2019 MArs revealed: - No transcribed entry for Forteo. - No staff initials to indicate Forteo was administered as ordered. Interview on 11/08/19 client #2 stated she received her medication as ordered. Interview on 11/06/19 and 11/12/19 the Administrator stated: - Client #2's Forteo had been discontinued. - She was unable to locate a discontinue order for client #2's Forteo. - She would follow up with client #2's physician regarding the order for Forteo. 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	Kept on file in the residents record. Administrator will follow-up to ensure all changes have been completed.	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

November 18, 2019

Ms. Priscilla Hardison, Director
Ms. Wendy Jones, Administrator
Wooded Acres Guest Home, Inc.
3706 Cherry Road
Washington, NC 27889

Re: Annual and Follow Up Survey completed November 12, 2019
Wooded Acres #2, 3644 Cherry Road, Washington, NC 27889
MHL # 007-054
E-mail Address: wjones@woodedacres.org

Dear Ms. Hardison and Ms. Jones:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed November 12, 2019.

As a result of the follow up survey, it was determined that one of the deficiencies is 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

- A re-cited standard level deficiency.
- The other tag cited is a standard level deficiency.

Time Frames for Compliance

- A re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is December 12, 2019.
- A standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is January 11, 2020.

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 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
Pam Pridgen, Administrative Assistant

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL007054 Y1	A. Building B. Wing Y2	11/12/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODED ACRES #2	3644 CHERRY ROAD WASHINGTON, NC 27889

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0114 Reg. # 27G .0207 LSC	Correction Completed 11/12/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Keith Hughes	DATE 11/12/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/18/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: NQCW12