STATE FORM

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED	
	MHL043-048	B. WING		R 09/02/2021
MALE OF BROWNER OF CURRY FR				09/02/2021
IAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE	
VOODHAVEN FAMILY CARE FACIL	ITY	ST ROAD		
	CAMER	RON, NC 28326		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
completed on 9/2/21. substantiated Intake is were cited. This facility is licensed category: 10A NCAC Living for Adults with I The Director of Opera Professional (QP) ref the Owner's wife. The Director of Opera & the Quality Improve from January 2021 under Interest of the Owner's wife. The Director of Opera & the Quality Improve from January 2021 under Interest of the Owner's wife. V 108 27G .0202 (F-I) Person Interest of the Owner's wife. V 108 27G .0202 (F-I) Person Interest of the Owner's wife. Interest of Opera Interest of Owner Interes	and complaint survey was The complaint was #NC00178752. Deficiencies If for the following service 27G .5600C Supervised Developmental Disability. ations/Qualified erenced in this report is tions/Qualified Professional ment Director filled in as QP til August 9, 2021 connel Requirements 2 PERSONNEL con shall be documented. programs shall be nimum, shall consist of conal orientation; ights and confidentiality as AC 27C, 27D, 27E, 27F e mh/dd/sa needs of the the treatment/habilitation us diseases and s. d under 10a NCAC ubchapter, at least one	V 108	It should be noted that the Di of Operations and the Quality Management Director did not as the responsible QP for the referenced periods from Janua 2021 to August 9, 2021. This time frame in the SOD is grossly inaccurate. The Provided oes have personnel records reflect person(s) who were in position for the majority of the period identified. Please note that Human Resofiles have been maintained to support the inaccuracy of this inaccuracy of this inaccuracy of this inaccuracy of the period identified.	fill in ary der to the QP time urces

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AND PLAN OF CORRECTION I IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED		
		MHL043-048	B. WING	B. WING		3
	PROVIDER OR SUPPLIER VEN FAMILY CARE FACIL	STREET ADI	ROAD	TATE, ZIP CODE	09/02	2/2021
			I, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 108	to provide cardiopulm trained in the Heimlich aid techniques such a Cross, the American H	agement, currently trained onary resuscitation and maneuver or other first is those provided by Red Heart Association or their ing airway obstruction. (i) shall develop and diprocedures for investigating and and communicable and clients.	V 108	The facility will ensure trainin staff and QP on goals and straidentified in the treatment planall assigned clients. Note that the plan of protection remains in effect since its implementation of 9/2/21. Client #1 was discharged from facility effective 9/3/21. The Behavior Analyst will in-set the assigned staff, including the on client #2 and client #3's behavior client #2 and client #3's behavior and possible productions.	ategies ns for n the ervice ne QP	
	Based on observation, interview the facility fails staff (staff #1, #7 & Quawere trained in goals are in the treatment plans. A. Review on 8/25/21 of record revealed: - date of hire: 4/17/1 - annual supervision "elements of person condividualized treatment and accuracy" signed Operations/QP & Qualit B. Review on 8/25/21 of record revealed: - date of hire: 8/16/2 - inservice training founderstanding documer	record review and ed to ensure 3 of 5 audited alified Professional (QP#2)) and strategies as identified The findings are: staff #1's personnel g plan dated 4-10-20: entered plan, plans, documentation by Director of y Improvement Director staff #7's personnel form dated 8/11/21: atation, review of client plan & review of client #1		intervention plan on 9/23/21. The Director of Operations did service the QP on all clients' treatment plans. The QP did in-service all assistaff on clients' treatment plans The QP will continue to monito the home 4-5 days a week to enthat staff demonstrate compete in the implementation of goals a strategies identified in the treat plans for all assigned clients as applicable.	gned s 9/ r in ensure encies and 9/2 ment	/23/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		100,000,000,000,000,000,000	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10 (C) = 10 (10 (10 (10 (10 (10 (10 (10 (10 (10	A. BUILDING	:		
		MHL043-048	B. WING		09	R / 02/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL					
			N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	Continued From page	2	V 108			
	Review on 8/25/21 record revealed: - date of hire: 8/9/2 - no documentation clients' treatment plans. The following are examfailed to ensure staff reneeds for client #1 & # Review on 8/25/21 of client #1 & # Review on 8/25/21 of client #1 & # Review on 8/25/21 of client #1's treatment/bel - refer to V112 for socient #1's treatment/bel - a behavior support "prevention: a structure given a key to the area keptall episodes of ch documented on the behavior and the behavior support of the plant of t	of QP#2's personnel of training on the s/behavioral plans inples of how the facility eceived training to meet the 2: client #1's record revealed: sm, Intellectual er (IDD), Bipolar, hearing epacific details regarding epavior support plan eplan dated 9/2/20: red environmentwill be where the knives are allenging behavior will be eavior tracking form" lient #2's record revealed: intellectual Disorder, Mood order, Schizoaffective explosive Disorder, Type II & Methicillin-Resistant (MRSA) specific details regarding havior support plan: d to consistently follow plan"				
	client #1 & #2 revealed: - 1 documented entr					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULT A. BUILD	IPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED		
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		WII 12043-046			09	/02/2021	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
WOODHA	VEN FAMILY CARE FACIL	436 WEST	ROAD				
WOODIIA	VENTAMILT CARE PACIL		N, NC 28326				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		T	_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETE DATE	
V 108	Continued From page	3	V 108				
	- 2 documented en	tries by staff #5 & #7					
	- 5/4/21 - physical a	altercation between client		The QP did in-service assign	ed	9/25/21	
	- July 2021 - 17 do	cumented behaviors	1	Staff on the need to keep the			
		locumented behaviors		sharps locked unless in use.			
	Review on 9/1/21 of a	n incident reported dated					
	8/26/21 "client (#1) v	vent into manic episode.					1
	Started by walking tow						
	knifeagitated and the						
	windows" signed by	staff #5					
	Observation between 2	2:02nm 2:00nm at					
	the facility revealed:	2.02pm - 3.00pm at					
		level cabinet that had 2				J	
	kitchen knives with sha						
		was attached to a metal				1	l
		nowever, it was unlocked					
		review on 9/1/21 between					
	11:11am - 11:30am the				1		
	Director gave tour of the	e facility which revealed					
	the following:	and containing of containing					1
	2 kitchen knives	ed unlocked with the same					
		ans & behavior support					
	plans in client #1 & #2'	s records					
	•	MODEL DE CONTROL					
	During interview on 8/2	4/21, 8/27/21 &					
	9/1/21 staff #1 reported	l:					
		ft from 3pm to 11pm			- 1		
	 worked 2 years at 						
		ty the longest besides			-		
1	another staff	1 - 1 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1					
1.		at the facility a year					
1	together	sues between the two					
	since client #1 was adn						
1		hysically fought each other					
	 within last 2 weeks 	: a crockpot was thrown,					
						1	

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
		MHL043-048	B. WING			R 9/ 02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS CITY S	STATE, ZIP CODE		5/02/2021	
		436 WES		STATE, ZIF GODE			
WOODHA	VEN FAMILY CARE FACIL	ITY	N, NC 28326				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 108	Continued From page	4	V 108	N -			
	of chalk at client #2 - sharps were not lo	other, client #1 threw a box					
	the lock where the kniv - never known any the lock off	of the clients to take					
	- client #1 might know how to remove the lock from the cabinet - she always completed behavior tracking logs - staff were not trained on how to complete the behavior tracking logs, but were given examples on how to complete them						
	During interview on 8/2 reported: - worked at the facil						
	 the first day on the a crockpot at client #2 	job client #1 threw					
1	 the crockpot did not client #1 & #2 foug she worked 						
	property and a contract of the	e" behaviors o be institutionalized" had a behavior. She					
-	(staff) wiped down the washed the dishes. Clie	kitchen table. Client #1 ent #2 yelled client #1 had					
	knife with a sharp blade	etside. It was long kitchen e. She could not tell if her to give her the knife or					
	to hurt her (staff #5) wit a look on her face that	h the knife. Client #1 had made it look like "she was					
6	and she (staff #5) ran o	d client #1 to run outside utside. She contacted the					
(go back inside and offe	QP. She instructed her to r coffee. She told her coffee jar, was throwing					
- 1	oots and pans & had a	knife. h the clients' behavior					

MMLOS-PROVIDER OR SUPPLIER WOODHAVEN FAMILY CARE FACILITY A36 WEST ROAD CAMERON, NC 28326 V 108 Continued From page 5 Support plans about knives being locked there was a combination lock on the cabinet with the knives at staff #1 informed her to leave the cabinet unlocked because staff didn't know the combination to the lock the clembar plans during orientation staff were to read the plans and ask the Director of Operations/OP any questions she would not call this training		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		B) DATE SURVEY COMPLETED	
MMLOS-PROVIDER OR SUPPLIER WOODHAVEN FAMILY CARE FACILITY A36 WEST ROAD CAMERON, NC 28326 V 108 Continued From page 5 Support plans about knives being locked there was a combination lock on the cabinet with the knives at staff #1 informed her to leave the cabinet unlocked because staff didn't know the combination to the lock the clembar plans during orientation staff were to read the plans and ask the Director of Operations/OP any questions she would not call this training				D. WILLO		1	R	
WOODHAVEN FAMILY CARE FACILITY CAMERON, NC 28336 CAMERON NC 28336 CAMERON NC 28336 CAMERON NC 28336 CAMERON NC 28336 CAMERON NC 28336 CAMERON NC 28336 CAMERON NC 28336 CAMERON OR LIST GENTIFYING INFORMATION) PREFIX TAG CROSS-REPERENCED TO THE APPROPRIATE CROSS-REPERENCED TO			MHL043-048	B. WING		09	/02/2021	
(X4) ID SUMMARY STATEMENT OF DEPICIENCIES TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LISC IDENTIFYING INFORMATION) V 108 Continued From page 5 support plans about knives being locked there was a combination lock on the cabinet with the knives she the cleints' behavior's support plans and ask the Director of Operations/OF any questions she would not call this training During interview on 8/24/21 staff #7 reported: had worked at the facility for a month cleint #1 8 #25 egitation & physical aggression towards each other between the two since she worked there does not feel comfortable working alone due to client #1 8 #25 egitation & physical aggression towards each other behavior's behavior's opport plans During interview on 8/24/21 staff #8 reported: had worked at the facility for a month client #1 8 #25 egitation & physical aggression towards each other between the two since she worked there does not feel comfortable working alone due to client #1 8 #25 egitation & physical aggression towards each other behavior/teatment plans no one sat down with her and individually went through the clients' treatment plans or behavior support plans During interview on 9/1/21 staff #8 reported: started work in August 2021 on second shift from 4:30pm - 10pm verified the 8/26/21 incident. Client #1 "went"	NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SUMMANY STATEMENT OF DEFICIENCIES GRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG	WOODHA	VEN FAMILY CARE FACIL	ITY 436 WEST	ROAD				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 108 Continued From page 5 support plans about knives being locked - there was a combination lock on the cabinet with the knives - staff #1 informed her to leave the cabinet unlocked because staff didn't know the combination to the lock - the clients' behavior support plans. Area the Director of Operations/OP any questions - staff were to read the plans and ask the Director of Operations/OP any questions - she would not call this training During interview on 8/24/21 staff #7 reported: - had worked at the facility for a month - client #1 & #2 were aggressive towards one another & argued a lot - there was one physical altercation between the two since she worked there - does not feel comfortable working alone due to client #1 & #2's agitation & physical aggression towards each other - both clients have behavior support plans - during orientation, the Director of Operations/OP gave staff at list of each clients' behaviors - she was not provided training on the behavior/treatment plans - no one sat down with her and individually went through the clients' treatment plans or behavior support plans During interview on 9/1/21 staff #8 reported: - started work in August 2021 on second shift from 4:30pm - 10pm - verified the 8/26/21 incident. Client #1 "went				I, NC 28326				
support plans about knives being locked there was a combination lock on the cabinet with the knives staff #1 informed her to leave the cabinet unlocked because staff didn't know the combination to the lock the clients' behavior support plans/treatment plans during orientation - staff were to read the plans and ask the Director of Operations/QP any questions - she would not call this training During interview on 8/24/21 staff #7 reported: - had worked at the facility for a month - client #1 & #2 were aggressive towards one another & argued a lot - there was one physical altercation between the two since she worked there - does not feel comfortable working alone due to client #1 & #2's agitation & physical aggression towards each other - both clients have behavior support plans - during orientation, the Director of Operations/QP gave staff a list of each clients' behaviors - she was not provided training on the behavior/treatment plans - no one sat down with her and individually went through the clients' treatment plans or behavior support plans During interview on 9/1/21 staff #8 reported: - started work in August 2021 on second shift from 4:30pm - 10pm - verified the 8/26/21 incident. Client #1 "went	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E IATE	(X5) COMPLETE DATE	
- she does not complete behavior tracking logs - worked with staff #5 & thought she completed the behavior tracking logs		support plans about kit - there was a comb with the knives - staff #1 informed cabinet unlocked becathe combination to the - the clients' behaving plans/treatment plans - staff were to read to Director of Operations/testee - she would not call During interview on 8/2 - had worked at the - client #1 & #2 were another & argued a lot - there was one phy between the two since - does not feel comf to client #1 & #2's agitatowards each other - both clients have be during orientation, Operations/QP gave state clients' behaviors - she was not provide behavior/treatment plans or behavior/underseatment plans or behavior during interview on 9/1/2 started work in Aug from 4:30pm - 10pm - verified the 8/26/21 crazy" - she does not comp worked with staff #5	her to leave the ause staff didn't know lock for support during orientation the plans and ask the QP any questions this training 24/21 staff #7 reported: facility for a month e aggressive towards one assical altercation she worked there fortable working alone due ation & physical aggression she Director of aff a list of each led training on the assith her and the clients' avior support plans (21) staff #8 reported: gust 2021 on second shift incident. Client #1 "went lete behavior tracking logs is & thought she completed	V 108	DETIGENCY			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION G:	(X3) DATE COM	SURVEY
			D. WING			R
		MHL043-048	B. WING		09/	02/2021
	ROVIDER OR SUPPLIER VEN FAMILY CARE FACILI	TY 436 WEST		TATE, ZIP CODE		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDERIS DI AMI OF CORRECTION		T
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETE DATE
	Operations/QP requestilents' behavior plans During interview on 8/2 reported: - client #2 had disrustaff were supposed to behaviors During interview on 8/2 he did not receive behavior support plans he read the clients treatment plans on his was not sure what Out) in client #2's behavior support it was important to treatment plans and be he read something client's behavior support it was important to treatment plans and be it could help decre aware of their triggers had not reviewed a tracking logs During interview on 8/2 of Operations/QP reports he went over "key behavior support plans orientation reviewed the client what triggered the client what triggere	sted she read the and ask questions 24/21 client #2's guardian aptive behaviors, however, be trained to address the 25/21 QP#2 reported: 1 any training on the clients' 3 & treatment plans 5' behavior support plans & own at the facility ETO (Exclusionary Time avior support plan) 9 about knives in one of the rt plans be trained on the clients' havior support plans ase clients' behaviors & be any of the clients' behavior 7/21 & 9/1/21 the Director ted: 9 elements" in the clients' with staff during s' likes and dislikes, ts nsibility to review the and ask questions for 2#2 to review the clients' behavior support plans	V 108	QP#2 denies that he express to the surveyor on his lack of training and understanding of behavior support plans. QP#2 will be provided training the behavior analyst on the besupport plans for Clients #2 ar The Director of Operations will review all treatment plans with QP#2 to ensure his understan and competencies to train staff. Client #1 was discharged effect 9/3/21. The plan of protection remains effect.	y by ehavior nd #3. I n the ding if.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED		
		MULOAGOAG	B. WING			R	
		MHL043-048	D. WING		09	/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
WOODHAY	VEN FAMILY CARE FACIL	436 WES	T ROAD				
WOODIIA	VENT AMILT CARL TACIL		N, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE	
V 108	Continued From page	2 7	V 108				
V 108	staff on how to complet logs - sharps are locked - staff knew the content the same as the combuster of the support plan about knit of the staff needed to assist of the staff needed to assist of the support plan	chavior tracking logs ement Director informed ate the behavior tracking In a cabinet abination to the lock, it was bination to the medications bething in her behavior ates atory of cooking and about knives in client #2's rview, she was not aware and was in client #2's ment plan or behavior ated, a copy should be acord at the facility 1/21 the Quality reported: acility were not locked by that clients grabbed art themselves or others and behaviors aview, he was not aware awas in client #2's crations/QP provided atreatment plans and and and and art plans were also	V 108				
	training on the complet tracking logs	non or the behavior					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	AND		(X3) DATE SURVEY COMPLETED	
			71. BOILDING	A.	1		
		MHL043-048	B. WING		09	R /02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
WOODHA	VEN FAMILY CARE FACIL	436 WES					
			N, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 108	Continued From page	8	V 108				
	This deficiency is cros NCAC 27G .0203 Con Professionals and Ass (V109) for a type A1 ru be corrected within 23	npetencies of Qualified sociate Professionals ule violation and must					
V 109	27G .0203 Privileging/	Training Professionals	V 109				
	qualified professionals (b) Qualified profession professionals shall den and abilities required by (c) At such time as a co employment system is then qualified professio professionals shall den (d) Competence shall be exhibiting core skills ind (1) technical knowledg (2) cultural awareness (3) analytical skills; (4) decision-making; (5) interpersonal skills (6) communication ski (7) clinical skills. (e) Qualified profession NCAC 27G .0104 (18)(met the requirements o based employment system for MH/DD/SAS. (f) The governing body of develop and implement	ESSIONALS AND SIONALS rivileging requirements for or associate professionals. In als and associate properties and procedures and procedures and procedures dividualized supervision					

Divisi	Division of Health Service Regulation					
STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP		X3) DATE COM	SURVEY
		MHL043-048	B. WING		09/	R 02/2021
NAME C	F PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
WOOD	HAVEN FAMILY CARE FACI	LITY 436 WES	ST ROAD			
		attended to the control of the contr	ON, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	: TE	(X5) COMPLETE DATE
V 1	(g) The associate pro supervised by a qual population served for	•	V 109	It should be noted that the Qual Management Director does not function in the capacity as the nor was this conveyed to the staurveyor. The facility will ensure that person	t QP, tate	9/25/21
	on observation, reco of 3 audited Qualified (Director of Operation Improvement Directo	ns/ (QP) & Quality or) failed to demonstrate d abilities required by the		functioning in the capacity of a demonstrates knowledge, skills abilities required to serve the population to include but not lin to the following. A-staff training will be provided goals, strategies identified in the treatment plans.	QP, s, nited	9/25/21 9/25/21
	PERSONNEL REQU Based on observation interview the facility for audited staff (staff #1 Professional (QP#2)) strategies as identifie B. Cross-reference ASSESSMENT AND TREATMENT/HABILI	n, record review and ailed to ensure 3 of 5, #7 & Qualified were trained in goals and d in the treatment plans. TATION OR SERVICE		B-The QP will monitor in the ho to ensure staff implement goals strategies for assigned clients. C-The QP will implement the disaster plan and staff to compledocumentation of disaster drills. D-The QP will provide training to staff to ansure all medications.	ete	9/25/21 9/25/21 9/25/21
	PLAN (V112). Based review and interview the simplement goals and needs for 2 of 3 audite to implement goals & audited clients (#3). C. Cross-reference EMERGENCY PLANS	on observation, record he facility failed to develop d strategies to meet the ed clients (#1 & #2) & failed		staff to ensure all medications a administered in accordance with physician's orders and staff complete documentation on the MAR for all assigned clients.	n the	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED					
			MHL043-048	B. WING		1	R 0 2/2021	
		ROVIDER OR SUPPLIER	TY 436 WEST	ROAD	TATE, ZIP CODE	09/0	J2/2021	-
ŀ		CUMMARYOT		I, NC 28326				
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETE DATE	
	V 109	NCAC 27G .0209 MEI REQUIREMENTS (V1 observation, record refacility failed to ensure administered on the wand MARs were kept of clients (#2 & #3). E. Cross-reference MEDICATION REQUIFOR record review and irrensure 1 of 1 audited copsychotropic medication had a drug regimen review. F. Cross-reference HEALTH CARE PERSO (V132). Based on record facility failed to have even was investigated and faworking days to Health (HCPR). G. Cross-reference OPERATIONS (V291) record review and intercoordinate with other cowho are responsible for (#1 & #2) treatment/ham. H. Cross-reference INCIDENT RESPONS FOR CATEGORY A AI	and disaster drills were a on each shift. Disc: 10A NCAC 27G 10A DICATION 118). Based on view and interview the emedications were ritten order of a physician current for 2 of 3 audited Die: 10A NCAC 27G .0209 REMENTS (V121). Based of the trivial to dient (#2) who was taking one for more than 6 months view every 6 months. Die: G.S.§131E-256 DNNEL REGISTRY of review and interview the idence an alleged abuse of the report within five care Personnel Registry Die: 10A NCAC 27G .5603 Die: Based on observation, review the facility failed to qualified professionals of 2 of 3 audited clients' billitation. Die: 10A NCAC 27G .0603 E REQUIREMENTS ND B PROVIDERS rd review and interview of the re	V 109	E-The Quality Management Director has set up a schedule the psychotropic medication 6 month review in coordination with the pharmacist. The review is scheduled for 9/28/21 for all circles of the pharmacist. The review is scheduled for 9/28/21 for all circles conducted investigations of a allegations. An investigation with conducted of the late report. G-The Director of Operations of a coordinate with Care Coordinate with Care Coordinate and QPs to address all client habilitation and treatment need when applicable. Meetings we conducted for client #1 and clief #2. H- The Quality Management Director will complete incident reports through IRIS when applicable for all allegations. A report was completed for the identified allegation.	with lients. lirector all vill be will ators ds re ent	9/25/21 9/25/21 9/25/21	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION G:	(X3) DATE COM	SURVEY 1PLETED
		MHL043-048	B. WING		00/	R 02/2021
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WOODHA	VEN FAMILY CARE FACIL					
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 109	CATEGORY A AND E Based on record revie failed to ensure a leve submitted to the LME/ Entity and the Manage 72 hours. J.Cross-reference: 10 POLICY ON RIGHTS INTERVENTIONS (V: review and interview trallegations of abuse for (#2) to the County De Services (DSS). K. Cross-reference LOCATION AND EXTI (V736). Based on obse governing body failed traffer from offensive L. Cross-reference FACILITY DESIGN AN Based on observation, interview the facility fail temperatures were main Review on 9/1/21 of the (QP) record revealed: hire date 6/1/05 job description: " monitor services, provie interventions to recipies facilitate initial developi	NG REQUIREMENTS FOR B PROVIDERS (V367). It wand interview the facility I II incident report was MCO (Local Management ed Care Organization) within II RESTRICTIONS AND Soo). Based on record the facility failed to report or 1 of 3 audited clients partment of Social e: 10A NCAC 27G .0303 ERIOR REQUIREMENTS ervation & interview the so maintain the facility in a land orderly manner and e odor. e: 10A NCAC 27G .0304 ID EQUIPMENT (V752). record review and led to ensure water intained between 100-116. e Director of Operations/ arrange, coordinate and de face-to-face therapeutic int and their family, ment and ongoing revision		I-The Quality Management Di will complete level 2 and 3 increports through IRIS when applicable for all allegations. A report was completed for the identified allegation. J- The Quality Management D did file a late report to DSS on late reported allegation. In the DSS will be contacted for all allegations. K-The QP will monitor in the hand implement the protection pensure the physical environment maintained, kept clean, in good repair and orderly. L-The QP will provide oversigh staff to ensure temperature chare completed. The QP will matemperature logs completed by The QP will address any variatin the temperature range outsid the norm.	virector the future ome olan to ent is d ot to ecks aintain staff. ions	9/25/21 9/25/21 9/25/21
	of person centered plan	n, implementation of the red person centered plan, monthly, orientate and				

		IDENTIFICATION NUMBER:	A. BUILDIN	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
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		WITE043-048	77.17.0		09/02/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
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WOODHA	VEN FAMILY CARE FACIL		N, NC 28326		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	T	PROVIDERIS DI ANI OF CORRECTION	
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 109	Continued From page	e 12	V 109		
	the consumer's care in promote family involved. During interview on 8/Operations/QP report - she did not work a - she filled in when - a QP was termina - another QP was hor April 2021 and wor - this QP quit without another State - filled in as QP until when QP#2 was hired - assisted with com	ng, keep in close and people involved in to encourage and ement" (27/21 the Director of ted: any shifts at the facility there was an absent QP ted January 2021 bired either March 2021 ked a month out notice & moved to (1) August 9, 2021 dipletion of treatment edication administration only meetings &			
	Director's record reveal hire date 11/1/11 job description: " improvement program management system, improvement, regulato reviewswork closely completion of audit prowith coordination and preededoverall operationganization" During interview on 9/1 Improvement Director	oversight for quality areas such as incident continuous quality ry compliance, policy with Director of Operations, neess for all charts, assist provide trainings as tional direction of the 1/21 the Quality reported: irect care services like ly living)			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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NAME OF B	ROVIDER OR SUPPLIER				09/0	02/2021
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WOODHA	VEN FAMILY CARE FACIL					
			N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 109	Continued From page	2 13	V 109			
V 109	- does not take clie physician appointmendue to her behaviors) - he currently filled facility was absent a Casthe Quality Imponitored the condition periodically reviewed needed, abuse/neglecasthe oversight of the physical environment, he did not supervised the dated 9/2/21 of the dated 9/2/21 written by Director revealed: "What facility take to ensure the in your care? [client #1] staffing effective immediated and cournentations. [QP#2] staff effective immediate and documentation of bestes. The Director of requested and emerger address the behavior contactions.	goals with the clients ints to appointments (last 2 its for client #2 he attended in as QP because the QP irrovement Director, he is on of the facility, MARs & annual or as it training it training it training it facility like: the bedrooms and bathrooms are any staff it is efacility's Plan of Protection in the Quality Improvement at immediate action will the ine safety of the consumers it will be assigned 1:1 diately during waking hours. Dehaviors between the 2 in-service staff on [client invior support plans effective intrategies to prevent future will in-service all assigned in incident reporting behavior data on log Operations/QP has not team meeting to oncerns with [client #1] and oordinators and guardian individualized support client #1 will move on iibe your plans to make	V 109	The plan of protection remains effect. Client #1 was discharge from the facility effective 9/3/2	ed	
	place and	ensure the actions are in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL	436 WES	Γ ROAD			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETE DATE
V 109	Developmental Disorder; Solntermittent Explosive Diabetes. Client #1 wayear ago. She and clie physically aggressive altercations between the client #2 with a black of #2's treatment plans of strategies to address the two clients. Both had be however, staff reported deal with the aggressive deal with the aggressive Behavior tracking logs consistently as recommended with the aggressive Behavior tracking logs consistently as recommended. Client #2 was with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a frying pan by a full provement Director with a find part of the provement of the allegation of the provement of the entire client #2 received medion 8/24/21. There were documented the entire client #2. Readings in comissing days. The water maintained between 10 facility, it had an offensing gnats throughout the fabedrooms had clothes of dressers. Client #2's bedrooms had clothes.	ents with Autism, Intellectual der, Bipolar, Mood Disorder, Chizoaffective Disorder, Disorder & Type II as admitted to the facility a ent #2 were verbally & towards one another. The fine two have resulted in eye and sutures. Client #1 & idn't have goals or the aggression between the enhavior support plans, at they were not trained to enhavior support plans, at they were not completed mended in the behavior e, the Director of equality Improvement eatment plans were not allegedly hit in the face former staff & the Quality was made aware of the mplete an incident report, ons or report the incident to S. Clients did not receive dered by their physician & te. Staff did not initial if cations for an entire day on blood sugars month of August 2021 for lient #2's glucometer were er temperatures were not 0-116. Upon entry to the ve odor & a surplus of	V 109	It should be noted that this altercation noted between Clie and Client #2- as identified doccur at the facility in question. In addition, there is no evidence suggest that alterations betwe Client #1 and Client #2 at the resulted in either client requiring medical treatment for any injurtact, there was no evidence of injuries at the facility from altercations between the 2 clies. It should be noted that it was alleged that Client #2 was accidentally hit with a pan as a sapproached the staff who was cooking or cleaning in the kitch. The staff in question had been terminated months after the lat report by the HCPR. The Quality Management Director was not months later of this alleged inc. The plan of protection remains effect. Client #3 was discharge effective 9/3/21.	lid not in. ce to en facility ng ries. In ents. che either nen. ce ity fied ident. in	

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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WOODHA	ROVIDER OR SUPPLIER VEN FAMILY CARE FACIL	ITY 436 WEST		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	depends with feces were in her toile. There was a missing bathroom which left a Director of Operations. Improvement Director oversight of the facilit constitutes a Type A1 neglect and must be a An administrative pen of the violation is not an additional administrative per day will be imposed is out of compliance between the constitutes and the violation is not an additional administrative pen day will be imposed is out of compliance between the constitution of the compliance between the constitution of the constitution o	vere on her bathroom floor, et and around the toilet. vent in client #1 & #3's hole in the floor. The s/QP & the Quality were responsible for the y. This deficiency rule violation for serious corrected within 23 days. ealty of \$5,000 is imposed. For each day the facilty eyond the 23rd day.	V 109	The surveyor conducted the sacross multiple weeks. The fin noted relative to water temper odor, bed frame repair needs, cleanliness etc. was corrected immediately. The surveyor ret for two (2) additional subsequivisits to the facility the following weeks and the issues were corrected. The QP continues to visit the Infection of the two surveyors and the issues were corrected.	ndings rature, d turned ent ng	9/25/21
	TREATMENT/HABILIT PLAN (c) The plan shall be of assessment, and in particular or legally responsible plays of admission for to receive services begin (d) The plan shall included in the plan shall included in the plan shall included by provision projected date of achies (2) strategies; (3) staff responsible; (4) a schedule for review annually in consultation legally responsible performance in the performance in the plan shall include in the plan shall in	ew of the plan at least n with the client or son or both; or assessment of		in the maintenance of the facil	ity.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-048	B. WING		09/	R 02/2021	
	ROVIDER OR SUPPLIER VEN FAMILY CARE FACIL	436 WES		STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE	
V 112	Continued From page provider stating why so be obtained.		V 112	The facility will ensure for all of that goals and program strate are developed and implement address priority needs.	gies	9/25/21	
	goals and strategies to audited clients (#1 & #2			Client #1 had a team meeting 9/9/21 which was facilitated by Director of Operations. Member present include but not limited Guardian, and the Care Coordinator. Discussion occur the client's medication regiment behavior pattern and moveme another facility. Client #1 was discharged on 9/3/21. The guardid approve of the movement.	y the ers to the rred of n, nt to		
	 admitted 7/16/20 diagnoses of Autis Developmental Disordeloss, & nonverbal treatment plan dat personal hygiene goals communication goals becomes upset or som way she exhibits a mul behaviorsimportant to planpicking up and the televisionsthreatened 	er (IDD), Bipolar, hearing ed 4/13/21: goals: s, independent living skills s: "when [client #1] ething does not go her titude of o follow behavior support prowing furniture and I harm to herself and staff		Client #2 had a team meeting 9/14/21 which was facilitated be Director of Operations. Member present include but not limited guardian and the Care Coordin Discussion occurred of the cliemedication regimen, behavior pattern. The team agreed on the plan noted, including the updat the behavior support plan.	y the ers to the nator. nt's	9/25/21	
: : : :	and other consumers a behavior support prevention: respond betructured environment, client #1 s] schedulea coffeewill be given a k knives are keptstaff wi assist [client #1] in obtain	plan dated 9/2/20: best to firm limits, a minimize changes to ssist her in a cup of ey to the area where the Il always be available to		For Client #3, the behavior sup plan was developed to address and use of a protective device.	port SIB	9/25/21	

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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	
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NAME OF P	ROVIDER OR SUPPLIER		DRESS CITY S	TATE, ZIP CODE	09/0	02/2021
	VEN FAMILY CARE FACIL	436 WEST				
WOODHA	VEN FAMILY CARE FACIL		I, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 112	behavior tracking form Operations/Qualified Quality Improvement - no goals or strates physical aggression b Review on 8/20/21 of - admitted 6/15/17 - diagnoses of Mild	nesall episodes of will be documented on the n" signed by Director of Professional (QP) & Director gies to address verbal &	V 112	The Behavior Analyst did in-sall assigned staff on the behavior support plans for client #2 and The in-service took place on 9/23/21. The QP was in-service well The Director of Operations did service the QP on the treatments.	vior d #3. ce as	9/25/21
	Disorder, Intermittent Diabetes, Hypertensio Staphylococcus Aureu - a treatment plan da socialization skills, indebudgeting & physical a	Explosive Disorder, Type II n & Methicillin-Resistant us (MRSA) ated 8/1/21: goals: ependent living skills, ggression: "because she exhibits extreme verbal and emove her from the		plans for clients #2 and #3. The QP did in-service all staff assigned to the home on the treatment plans for clients #2 a #3. It should be noted that client #	and	9/2/21
	bothering herhas a be place and according to according to the reside of [client #2's] behavior verbal aggression, physical	ehavior support plan in her treatment team and ntial staff should make use al plan which addresses sical aggression plan with no date but		discharged from the facility effe 9/3/21. The plan of protection remains effect as the QP conducts	ective (9/25/21
	[client #2] has threaten knife. That being the cahome will be kept in a sused under staff supernexhibits aggressive bether to leave for - exclus (ETO)all episodes of be documented on the	ed to harm others with a ase, knives at the group secured area and will be visionif [client #2] havior staff will initially ask sionary time out challenging behavior will behavior tracking form"		monitoring in the home 4-5 time weekly to ensure continued compliance. Knives and sharps remain lock. The monitoring sheet complete the QP reflects no major issues the home to include but not limit oclient behavior challenges,	ed.	9/25/21
	Review on 8/27/21 of a			cleanliness concerns or inciden	its.	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		TOLIZOZ I	
WOODHA	VEN FAMILY CARE FACIL	436 WEST					
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
	dated 4/15/21 for clier - "patient present behavior continues. SI an altercation with a per Review on 8/20/21 of a - admitted 6/25/18 - diagnoses of: Auti Profound Intellectual D Cerebral Palsy, Mood I Dyslipidemia, Hyperter and Seizure Disorder - a treatment plan d to greet others daily, so a independent living sk hands) Review on 8/27/21 of t tracking forms from Ap client #1 & #2 revealed - May 2021 - 1 phys - July 2021 - 1 phys - July 2021 - 2 pl Review on 8/27/21 of tl report log regarding an at the day program rev - "8/9/21to whom i hit [client #2] with time o hit [client #1] back but s	at #2 revealed: s with staff. The combative he has a black-eye due to heer (client #1)" client #3's record revealed: stic Spectrum Disorder, hevelopmental Disorder, Disorder, history of history	V 112				
	Observation & interview between 1:42pm - 1:49 program revealed: - right side of client # a white bandage - spoke in broken se	w with client #2 on 8/13/21 pm of client #2 at the day #2's forehead covered with entences at #2] dangerous" then					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	03/0	2/2021
WOODHA	VEN FAMILY CARE FACILI	TY 436 WEST	ROAD			
			I, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	19	V 112			
		on a shelf outside the front strance of the day program				
	reported:	13/21 the day program QP ent #1 and #2 had a				
		8/9/21 prior to the arrival				
- as soon as they arrived to the day program, client #1 grabbed the time clock, threw it and hit client #2 in the head - it happened so fast, however, staff were able to separate the two						
		parate at the day program				
	 no physical aggres the day program 	ssion between the two at				(90)
	Review on 9/1/21 of the log revealed: - 8/26/21 - "Client (#	e facility's incident report				
	episode. Started by wa knife, proceeded to get	lking towards me with a agitated and throw				
	fire extinguisher, threw	v and coffee table. Threw dish water, threw coffee ground" signed by staff				
	#5	ground Signed by stain				
	staff between 2:00pm - revealed:	,				
	2 kitchen knives with sh - a combination lock	was attached to a metal				
1.	piece on the cabinet, ho - 3 kitchen windows with tall kitchen drawstri	broken out covered up				
;		maintenance was in				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		SURVEY
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WOODHA	VEN FAMILY CARE FACIL					
			ON, NC 28326			
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				DEFICIENCY)		
V 112	Continued From pag	9.20	V 112			1
	l commuca i form pag	6 20	V 112			
	Observation on 9/1/21					
		mprovement Director gave				
		ch revealed the following:				•
		ned unlocked with the same				
	2 kitchen knives					
	During intention on 9	3/24/21 staff #1 reported:				
		s at the facility on second				
	shift from 3pm - 11pm					
1		ed at the facility about a year				
	together	a at the lability about a year				
	- they had a lot of b	ehavioral issues				
	- a lot of days client #1 & #2 fought					
		kitchen chairs at each other				
	- client #2 was the					
	 client #2 talked a l 					
		verbal & hearing impaired				
	but "felt a person's mo					
		eeks: a crockpot was				
		rown at each other and				
	client #1 threw a box o					1 1
	- no injuries witness					1 1
	- It could be hard to	get client #1 to calm down pice & redirected client #1 &				
1	#2's behaviors	once & redirected client #1 &				
		did not explain how to				
		s aggressive behaviors				
	between each other	aggressive benaviors				
	- staff had to "figure	it out for themselves"				
		cked & she was not				
	told they had to be loc					
		e the combination to				
	the lock where the kniv					
		2.39				
		24/21 staff #5 reported:				
	- worked at the facili					
	second shift from 3pm					
		orked client #1 threw a			1	
	crockpot at client #2. Ti	ne crockpot did not hit	1		i	

		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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VV	ООДНА	VEN FAMILY CARE FACIL	CAMERON	NC 28326			
Р	X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
		client #2. Both fought to both have aggress last week client # (staff) wiped down the washed the dishes. Cl a knife. Staff #8 was o knife with a sharp blad client #1 came toward to hurt her (staff #5) wa look on her face that coming for me." She to and she (staff #5) rand she (staff #1) had broke the pots and pans & had a there was nothing support plans about knithere was a combine with the knives staff #1 informed hunlocked because staff combination to the lock client #2 liked certashe was new & client #2 liked certashe was new & client #2 the she was nonverbal the behavior plans handle client #1 & #2's between each other During interview 9/1/21 started work in Augfrom 4:30pm - 10pm verified the 8/26/21 crazy" she does not comp	that day. sive behaviors 1 had a behavior. She kitchen table. Client #1 ient #2 yelled client #1 had utside. It was long kitchen le. She could not tell if her to give her the knife or ith the knife. Client #1 had made it look like "she was old client #1 to run outside outside. She contacted the (QP. She instructed her to er coffee. She told her e coffee jar, was throwing knife. in the clients' behavior ives being locked mation lock on the cabinet didn't know the ain staff ent #2 did not listen to her to her bedroom when she direct client #1 because did not explain how to aggressive behaviors	V 112	DEFICIENCY		

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If continuation sheet 23 of 59

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL043-048	B. WING			R 0 2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STDEET A	DDDESS CITY ST	ATE ZIR CORE		02/2021	
7	NO VIDEN ON OUT FEET	436 WES	DDRESS, CITY, STA	ATE, ZIP CODE			
WOODHA	VEN FAMILY CARE FACIL	ITY	N, NC 28326				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				т —	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 112	Continued From page	22	V 112				
	the behavior tracking I	ogs					
	- had worked at the - 7am - client #1 & #2 were another - one of them was s the facility but she was - client #1 & #2 arg - client #1 & 2 had o since she had been at t getting off shift and clien Then client #1 threw a p #1 was deaf and nonver redirect her during this "a big girl" and moved - could usually redir #2 to her room to calm - didn't feel comforta #1 & #2 due to the agit aggression toward eac - does not work on a	need a lot ne physical altercation he facility. She was nt #2 pointed at client #1. poillow at client #2. Client erbal. It was hard to incident. Client #1 was her out of the way. ect client #1 & send client down able being alone with client ation & physical					
	reported:	4/21 client #1's guardian					
	she didn't blame cl protecting herself the other female (c and pointed at client #1 client #1 was nonv impaired, however coul client #1 picked up client (#2) and she requ	e facility attacked client #1 ient #1 for lient #2) taunted erbal and hearing d read lips a clock and hit the other					
	she had not been in						

	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G:	(X3) DATE COM	SURVEY PLETED
		MHL043-048	B. WING		Ì	R 02/2021
	(EACH DEFICIENC	ITY 436 WEST	ROAD N, NC 28326	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	BE	(X5) COMPLETE
V 1	Continued From page Quality Improvem 12, 2021 to discuss in client #1 & #2 we she had not heard a treatment team discussed to address the two clients a team meeting of to address the clients would like to know moved if she was not client #1 needed t the reasons for he high turnover of staff During interview on 8/ Coordinator reported: care coordinators there had been no getting along with her if she was not gett housemates, he would a team meeting co strategies in place strategies could be with additional staff he spoke with the I on 8/17/21 to see how she informed him of increased due to client he was concerned additional staff were in the Director of Ope additional funds were in a new QP that filled in During interview on 8/2 started 8/9/21 at th he did not work full	e 23 lent Director called August noving client #1 re not getting along d back from him meeting had not been the behaviors between build be beneficial behaviors why client #1 had to be the aggressor he same staff or behaviors could be the 30/21 client #2's Care ince March 2021 bissues with client #2 housemates ing along with d like to know uld have happened to put to increase monitoring Director of Operations/QP client #2 was doing of a medication being #2's behaviors and asked if funds for eeded erations/QP said not needed as they hired at the facility 25/21 QP#2 reported: e facility	V 112	The Director of Operations we facilitate contact with the Care Coordinators to ensure that meetings are scheduled to adclient behavior challenges and develop a plan to address such challenges to include staff trainallocation of resources or environmental adaptations. Client #1's team meeting was on 9/9/21. In attendance were Care Coordinator and the guar amongst facility staff. The team meeting was documented in the record. Client #2's team meeting was on 9/14/21. In attendance were Care Coordinator and the guar amongst facility staff. The team meeting was documented in the record. Client #1 was discharged from facility effective 9/3/21. The plan of protection remains effect and is implemented by the QP. The facility maintains documentation of monitoring by QP in the home.	ill dress d th ning, held the rdian ne held e the rdian n e	9/25/21 9/25/21

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	LAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		
		MHL043-048	B. WING			
	OF PROVIDER OR SUPPLIER OHAVEN FAMILY CARE FACIL	ITY 436 WES	DDRESS, CITY, STAT T ROAD DN, NC 28326	E, ZIP CODE	09/02/2021	
(X4) I PREF TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V	hit client #2 - he was able to defurther - client #1 seemed - he requested staff agitation & engage cli During interview on 8 of Operations/QP rep - client #1 & #2 wel - verified the 4/15/2 - spoke with client # favor with her being red - no treatment team client #1 & #2's behaved - the Care Coordinate made aware of the client #1 a cup of coffed - staff were to keep clients at all times, keed client #1 a cup of coffed - QP#2 will work from second shift - during staff meeting needed to complete the it helped to update plans/treatment plans logs were completed of the complete of the client #1 & #2 do red to the complete of the client #1 & #2 do red to the complete of the client #1 & #2 do red to the complete of the client #1 & #2 do red to the client #1 to a monday (8/9/21) continue clock and client #1 to a the client #1 to a the clock and client #1 to a the client #1 to a the clock and client #1 to a the c	escalate before it went any to be the aggressor to monitor signs of ent #1 in something /27/21 the Director orted: re not "compatible" 11 medical consult 1's guardian and she was in located to a sister facility n meetings to address viors stor called monthly and was ents' behaviors their eye sight on both the them deescalated, give the & redirect client #2 the assister facility may a sister facility to the behavior tracking logs to the behavior tracking logs the behavior tracking consistently 13/21 & 9/1/21 the Quality reported: tot get along al Management Organization's approval to sister facility lient #1 hit client #2 with a 2 required 4 - 5 sutures 21) client #1 threw a pot to	V 112			

Division of Health Service Regulation

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333/52		OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	LE CONSTRUCTION G:	(X3) DATE S COMF	SURVEY PLETED
			MILLI OAD OAD	B. WING		1	R
-			MHL043-048	B. WING		09/0	2/2021
		ROVIDER OR SUPPLIER VEN FAMILY CARE FACIL	436 WEST		STATE, ZIP CODE		
PF	(4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
	V 112	- client #2 used to be #1 fought back now - client #1's behavior admitted to the facility - both have behaviors - client #2's Depaked due to the high freque between she and client - hired QP#2 as addenoted a staff were requested separated, get in front #2 to her bedroom, igridirect positive attention the clients' behavior subhaviors on the behaviors on the behaviors on the behavior subhaviors on the behavior support ould be updated to a aggression between e	ore the aggressor but client ors have increased since or with client #2 or plans to address ote had been adjusted ency of behaviors out #1 ditional staff to work 3pm and to keep them both of client #1 & redirect client ency client #2's behaviors, out to questions and follow apport plans ment all client #1 & #2's evior tracking logs he behavior tracking forms f2 would correct out plans & treatment plans didress client #1 & #2's ach other so referenced into 10A ency to the plans of Qualified ociate Professionals alle violation and must	V 112	The Behavior Analyst did in-sall staff and QP on the behavior support plan for Clients #2 and Discussion of behavior tracking forms and documentation of behavior data was part of the discussion as well. In-service are on file to reflect this training behavior support plans for aforementioned clients. Client #1 was discharged effect 9/3/21. The plan of protection remains in effect.	or d #3. ng sheets ng on	9/23/21
	V 114	area-wide disaster plar and shall be approved local authority.	EMERGENCY San for each facility and a shall be developed	V 114			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	SURVEY 1PLETED
		MHL043-048	B. WING		004	R (02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	1 09/	02/2021
WOODHA	VEN FAMILY CARE FACIL	436 WEST				
	Value of the value	CAMERON	I, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETE DATE
V 114	and evacuation proced be posted in the facility (c) Fire and disaster dishall be held at least quere repeated for each shift, under conditions that s	dures and routes shall y. rills in a 24-hour facility	V 114	The facility will ensure evacual drills are conducted at least quarterly under varied conditions each shift in the home. The Residential Manager /QP service the staff in the home conducted at least quarterly under varied conduction process and scheme conduction process.	ons for will in	
	failed to ensure fire and completed quarterly & findings are: Review on 9/1/21 of the log revealed: - one documented fit conducted on 8/23/21	w and interview the facility d disaster drills were on each shift. The e facility's fire and disaster		The evacuation schedule will to posted for staff review. The Residential Manager will track evacuations on a monthly basis ensure compliance. The Quality Management Direwill review all evacuation drills monthly basis to ensure contin	all is to ctor on a	9/25/21
	disaster drills would be she had not comple she had been at the face for a fire drill, she w to meet outside in the y tornado drill they w During interview on 8/20 Deparations/QP reported	facility since 2019 QP (Qualified ly 2021 I a schedule of when fire & completed eted any drills since cility vould have the clients ard ould get in a closet				

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
		MHL043-048	B. WING		R 09/02/2021
	ROVIDER OR SUPPLIER	TY 436 WES	DDRESS, CITY, ST T ROAD DN, NC 28326	「ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE
	disaster drills were co- the prior QP work or April 2021 - staff have not bee fire and disaster drill I - QP#2 started Aug the fire and disaster d During interview on 9, Improvement Director - the QP was respo drills being done - QP#2 completed t This deficiency constit This deficiency is cross NCAC 27G .0203 Cor Professionals and Ass (V109) for a type A1 re be corrected within 23 27G .0209 (C) Medical 10A NCAC 27G .0209 REQUIREMENTS (c) Medication adminis (1) Prescription or non-ponly be administered to	ompleted ed a month in March on able to locate the facility's ogs since she left ust 2021 & has resumed rills (1/21 the Quality reported: nsible for fire & disaster the 8/23/21 drill tutes a re-cited deficiency as referenced into 10A repetencies of Qualified sociate Professionals alle violation and must days. tion Requirements MEDICATION stration: prescription drugs shall a client on the written rized by law to prescribe eself-administered by prized in writing by the ag injections, shall be	V 114		
	pharmacist or other lega	ned by a registered nurse, ally qualified person and d administer medications.			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION G:	(X3) DATE COM	SURVEY IPLETED
		MHL043-048	B. WING		09/	R 02/2021
	ROVIDER OR SUPPLIER	TY 436 WEST		STATE, ZIP CODE	03/	02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Æ ATE	(X5) COMPLETE DATE
	(4) A Medication Admiall drugs administered kept current. Medication recorded immediately MAR is to include the form (A) client's name; (B) name, strength, and (C) instructions for add (D) date and time the (E) name or initials of the drug. (5) Client requests for inchecks shall be recorded MAR file followed up by consultation with a physical property of the drug of the drug of the drug of the drug of the drug. This Rule is not met as observation, record reversely facility failed to ensure administered on the writing and MARs were kept of the drug of	nistration Record (MAR) of to each client must be ons administered shall be after administration. The following: Ind quantity of the drug; ministering the drug; drug is administered; and of person administering medication changes or ed and kept with the yappointment or sician. evidenced by: Based on iew and interview the medications were tten order of a physician arrent for 2 of 3 audited andings are: If client #2's record Intellectual Disorder, Mood order, Schizoaffective plosive Disorder, Type II & Methicillin-Resistant		The facility will ensure that medications are administered compliance with physician's or and documentation is complet accurate on the MAR. For Client #2, glucose reading be documented as noted in the physician's orders. For Client # 3 the QP will proviservice training to all staff on administration of medications. will be instructed to administer medications and confirm through crosswalk of the MAR during emedication pass. The QP will monitor the MARs clients, 4-5 times weekly in the home to ensure continued compliance. The facility will ensure that the medication administration system accurate and reflective of the physician's orders. The Directo Operations will review physician orders weekly to ensure MAR reflects medications that are administrated as prescribed. The QP will in-service all staff in the QP will in-service all staff in the QP will in-service all staff in the physician orders are administrated as prescribed.	rders re and rs will re ride in- Staff all gh a rach for all	9/25/21
F	Review on 8/20/21 of th	,		home on documentation on the MAR.		

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	MHL043-048	B. WING		1	
				1	R
				09/0	2/2021
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
OODHAVEN FAMILY CARE FACIL	ITY 436 WEST	ROAD			
		I, NC 28326			
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
(microgram) daily (hyp 12/2/20 - Duloxet (depression) 4/15/21 - Quet twice a day (Schizophi 2/22/21 - Metform day (Diabetes) 8/3/21 - Divalpros (bipolar) Observation on 8/20/2 medications revealed: - Divalproex 2 500m - dispensed on 8/12 Observation on 9/1/21 11:22am of some of clir readings in the glucome - 8/24/21 - 143 - 8/25/21 - 137 - 8/26/21 - 148 - no reading for 8/27 - 8/28/21 - 168 - 8/29/21 - 159 - 8/30/21 - 147 - no reading for 8/31 Record review on 8/20/#2's August MAR 2021 - no documentation the entire month - Divalproex 500mg	yealed: yroxine Sodium 50mcg bothyroidism) tine 30 mg (milligram) daily tiapine Fumarate 200mg renia) tin 500mg three times a ex 1000mg QHS (bedtime) 1 at 3:40pm of client #2's ang QHS 2/21 between 11:21am - tent #2's blood sugar eter revealed: 7/21 //22 //22 //22 //23 //////////	V 118	The Quality Management Dir and/or the Director of Operativill review MARs weekly in the home to ensure continued compliance.	ons	9/25/21

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY MPLETED
		MHL043-048	B. WING		00	R /02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS CITY STAT	TE ZID CODE	09	/02/2021
		436 WE	ADDRESS, CITY, STAT ST ROAD	E, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL	JITY	ON, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	1000mg QHS on 8/3/2 it could not be filled ur Divalproex was discor - she contacted the 8/3/21 and left a mess - on 8/11/21 she left a requested the discorthed discorthed the discorthed discorthed the discorthed for the facility started was 12/21 - the facility started was 12/21 because the present of the facility started of the discorthed pharmac - was not sure if the the 8/3/21 Divalproex pharmacy - the documentation missed During interview on 8/2 at the he observed missing several days - he contacted staff of the medication error - medications were a staff forgot to initial During interview on 9/2 Improvement Director - no documentation of sugar checks	/30/21 the pharmacy n order for Divalproex 21 for client #2, however, ntil the previous ntinued physician's office on sage it another message ontinue order der was received with their pharmacy on evious pharmacy closed 20/21 the Director of rofessional (QP) reported: y on 8/1/21 previous pharmacy sent prescription to the new a error for Divalproex was 25/21 QP#2 reported: ne facility ng staff initials on and made them aware rs administered but	V 118	DEFICIENCY)		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL043-048	B. WING			R
		WITE043-046			09/	02/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL	ITY 436 WES	T ROAD			
		CAMERO	N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	31	V 118			
	sugar log sheet for stablood sugars - they started with - he would inform siblood sugar checks on B. Review on 8/20/21 revealed: - admitted 6/25/18 - diagnoses of: Auti Profound Intellectual Dicerebral Palsy, Mood in Dyslipidemia, Hyperter and Seizure Disorder - a physician's order sprinkles 125mg 6 twice Review on 8/20/21 of 68 August 2021 MAR results and provinces prinkles - Divalproex sprinkles	anew pharmacy on 8/1/21 staff to document in the back of the MAR of client #3's record stic Spectrum Disorder; evelopmental Disorder, Disorder, history of ision, Chronic Constipation or dated 6/28/21 Divalproex is a day on food	VIII			
	medications revealed: - Divalproex sprinkle - Divalproex sprinkle During interview on 8/3 technician reported: - a physician order of sprinkles twice day was - received a physicia for 6 capsules twice a of on 8/26/21 & back to 3 During interview on 8/2 Operations/QP: - she & the Quality In rotated who visited the she checked MAR	dated 6/22/21 three 125mg s on file an's order dated 8/24/21 day but it was discontinued twice a day 7/21 the Director of mprovement Director				

AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	LE CONSTRUCTION G:	(X3) DATE COM	SURVEY MPLETED
		MHL043-048	B. WING		09/	R 02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		02/2021
WOODHA	VEN FAMILY CARE FACIL		ROAD N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 118	Continued From page	32	V 118			
	ensured MARs & med	ications were accurate				
V 121	During interview on 8. Improvement Director - MARs should be reveal week - QP#2 will have to Due to the failure to accommodication administrated determined if clients remedications as ordered. This deficiency constituted This deficiency is cross NCAC 27G .0203 Comprofessionals and Assa (V109) for a type A1 respectively of the corrected within 23 and NCAC 27G .0209 (F) Medication review: 10A NCAC 27G .0209 (F) Medication review: (1) If the client receives governing body or oper for obtaining a review of the second	/20/21 the Quality reported: reviewed at least twice a "stay on top" of the MARs ccurately document tion it could not be eceived their d by the physician utes a re-cited deficiency as referenced into 10A npetencies of Qualified sociate Professionals ule violation and must days. on Requirements MEDICATION psychotropic drugs, the ator shall be responsible f each client's drug	V 121	The facility will ensure that dru regimen reviews are complete every 6 months for clients who ingest psychoactive medication. The Quality Management Direwill coordinate onsite visits from new pharmacist to complete diregimen reviews on all clients in home. The drug regimen review is scheduled for 9/28/21 as the pharmacist will be onsite to complete the reviews for all clients in the facility.	otor m the rug in the	9/25/21
	the client's physician is the review when medica (2)The findings of the co	d by a pharmacist or nanager shall assure that informed of the results of al intervention is indicated. drug regimen review e client record along with		A copy of the drug regimen rev will be filed in each client's record the Quality Management Direct will monitor quarterly and coord with the new pharmacist to enscontinued compliance with ever months drug review.	ord. ctor dinate ure	

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COM	SURVEY IPLETED
	MHL043-048	B. WING	B. WING		
NAME OF PROVIDER OR SUPPLIER	STREET	DDDESS CITY STAT	FF 7/D 0005	1 09/	02/2021
	436 WES	ADDRESS, CITY, STAT ST ROAD	TE, ZIP CODE		
WOODHAVEN FAMILY CARE FA	CILITY	ON, NC 28326			
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	1 - 1	PROVIDER'S BLANCE CORRECTION		1
PREFIX (EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 121 Continued From pa	age 33	V 121			
This Rule is not me Based on record re failed to ensure 1 of was taking psychothan 6 months had 6 months. The find Review on 8/20/21 - admitted 6/15/1 - diagnoses of M Disorder, Psychotic Disorder, Intermitte Diabetes, Hyperten Staphylococcus Au - a physician's or 500 milligrams at be - no documentati During interview on Operations/Qualified - they changed pl 2021 - she was not abl regimen reviews co During interview on Improvement Direct - the pharmacist so Operations/QP the I regimens - the Director of Opharmacist didn't giv reviews - there were no do reviews for the last y	et as evidenced by: eview and interview the facility of 1 audited client (#2) who tropic medications for more a drug regimen review every ings are: of client #2's record revealed: 7 ild Intellectual Disorder, Mood c Disorder, Schizoaffective nt Explosive Disorder, Type II sion & Methicillin-Resistant reus (MRSA) der dated 6/14/20: Depakote edtime (treat bipolar) on of a drug regimen review 8/27/21 the Director of d Professional (QP) reported: harmacist the end of July e to locate the drug mpleted by the pharmacist 9/1/21 the Quality or reported: said he gave the Director of last 3 completed drug perations/QP said the re her any drug regimen ocumented drug regimen				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	ACCOUNT OF THE PERSON NAMED IN	SURVEY MPLETED
			A. BOILDING	3.	-	
		MHL043-048	B. WING		09	R /02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	STATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL	ITY 436 WEST	ΓROAD			
			N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 121	Continued From page	34	V 121			
	This deficiency is cros NCAC 27G .0203 Con Professionals and Ass (V109) for a type A1 ru be corrected within 23	npetencies of Qualified ociate Professionals le violation and must				
V 132	G.S. 131E-256(G) HCl Allegations, & Protection	PR-Notification, on	V 132			
i	REGISTRY (g) Health care facilities. Department is notified health care personnel, unknown source, which any act listed in subdiv (which includes: a. Neglect or abuse of facility or a person to who defined by G.S. 131E-13 defined by G.S. 131E-20 b. Misappropriation of resident in a health care subsection (b) of this sewhere home care service 131E-136 or hospice set 131E-201 are being procedule. Misappropriation of healthcare facility. d. Diversion of drugs of facility or to a patient or elements or clier is providing services).	of all allegations against including injuries of appear to be related to ision (a)(1) of this section. If a resident in a healthcare om home care services as 36 or hospice services as 31 are being provided. If the property of a services as defined in section including places as defined by G.S. services as de				

NAME OF PROVIDER OR SUPPLIER WOODHAVEN FAMILY CARE FACILITY CAMERON, NC 28326 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG COntinued From page 35 investigations must be reported to the Department. V 132 Continued From page 35 investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to health Care Personnel Register. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to health Care Personnel Registry (HCPR). The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Spizical felicity. SUMMARY STATEMENT OF DEFICIENCY: PREFIX (EACH CORRECTION, (EACH CORRECTION) (EACH CORRECTION, (EACH CORRECTION) (EACH CORRECTION, (EACH CORRECTION) (EACH CORR	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED R 09/02/2021	
NAME OF PROVIDER OR SUPPLIER WOODHAVEN FAMILY CARE FACILITY CAMERON, NC 28326 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PROVIDERS PLAN OF CORRECTION BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY; V 132 Continued From page 35 Investigations must be reported to the Department within five working days of the initial notification to the Department. V 132 The facility will ensure that all allegations of physical abuse are investigated and reported to the Health Care Personnel Register. The HCPR staff did not under any circumstances suggest that the Quality Management Director complete an internal investigation. There is no email trail or written documentation from the HCPR to suggest that this direction was given. In fact, there was no clear allegation of physical abuse that was inferred. Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to Health Care Personnel Registry (HCPR). The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Schizoaffective Suggest that the Director of Quality (In any event the Direct			MHL043-048	B. WING			
V 132 Continued From page 35 investigations must be reported to the Department within five working days of the initial notification to the Department. The facility will ensure that all allegations of physical abuse are investigated and reported to the Health Care Personnel Register. The HCPR staff did not under any circumstances suggest that the Quality Management Director complete an internal investigation. There is no email trail or written documentation from the HCPR to suggest that this direction was given. In fact, there was no clear allegation of physical abuse that was inferred. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to Health Care Personnel Registry (HCPR). The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective	WOODHAV (X4) ID	/EN FAMILY CARE FACIL	ATEMENT OF DEFICIENCIES 436 WEST CAMEROL	ROAD N, NC 28326	PROVIDER'S PLAN OF CORRECTION		(X5)
investigations must be reported to the Department within five working days of the initial notification to the Department. The facility will ensure that all allegations of physical abuse are investigated and reported to the Health Care Personnel Register. The HCPR staff did not under any circumstances suggest that the Quality Management Director complete an internal investigation. There is no email trail or written documentation from the HCPR to suggest that this direction was given. In fact, there was no clear allegation of physical abuse that was inferred. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to Health Care Personnel Registry (HCPR). The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective	The second secon	REGULATORY OR I	SC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRI	BE ATE	COMPLETE DATE
Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) During interview on 8/23/21 a HCPR representative reported: - during a separate investigation at the facility, staff #1 alleged former staff (FS #6) hit client #2 in the face with a frying pan - she (HCPR) informed the Quality Jack Those Specifics, Site only said it was an accident as client was hit as she charged the staff while staff was holding the pan and it was an accident and not an allegation of physical abuse. The investigation will comprise staff statement and will be uploaded to		investigations must b Department within fivinitial notification to the This Rule is not met a Based on record revie facility failed to have e was investigated and f working days to Health Registry (HCPR). The Review on 8/20/21 of admitted 6/15/17 diagnoses of Mild In Disorder, Psychotic Dis Disorder, Intermittent E Diabetes, Hypertension Staphylococcus Aureus During interview on 8/2 representative reporter during a separate in staff #1 alleged former	e reported to the e working days of the ne Department. s evidenced by: w and interview the vidence an alleged abuse failed to report within five n Care Personnel findings are: client #2's record revealed: intellectual Disorder, Mood sorder, Schizoaffective explosive Disorder, Type II n & Methicillin-Resistant s (MRSA) 23/21 a HCPR d: investigation at the facility, staff (FS #6) hit client #2		The facility will ensure that all allegations of physical abuse investigated and reported to the Health Care Personnel Regist. The HCPR staff did not under circumstances suggest that the Quality Management Director complete an internal investigat. There is no email trail or writted documentation from the HCPF suggest that this direction was given. In fact, there was no cleallegation of physical abuse the was inferred. In any event the Director of Quanagement initiated an IRIS and opened an investigation. The staff who alleged to have the HCPR official indicated that did not share those specifics, sonly said it was an accident as was hit as she charged the state while staff was holding the panit was an accident and not an allegation of physical abuse. The investigation will comprise	are ne tion. n n n n n n n n n n n n n n n n n n	9/25/21

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAY DEFICIENCY)			OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	LE CONSTRUCTION G:	(X3) DATE COM	SURVEY PLETED
MAKE OF PROVIDER OR SUPPLIER WOODHAVEN FAMILY CARE FACILITY CAMERON, NC 28326 [X4] ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES TAG X 132 Continued From page 36 - their agency still had not received the investigation During interview on 8/24/21 staff #1 reported: - a year ago. she (staff #1) witnessed client #2 spit in FS#6's face - it happened so fast with client #2 having a behavior - FS#6 prapared dinner - FS#6 seads he would write up an incident report - she idnot report the incident to anybody because she thought FS#6 wrote an incident report - she informed a lady that worked for the State (HHCPR) about the incident - did not recall the lady's name - management birector of Operations/Qualified Professional (QP) reported: - she was not aware FS#6 allegedly int client #2 in the face with a pan - all allegations of abuse should be reported During interview on 9/1/21 the Quality Improvement Director reported: - she was not aware FS#6 allegedly hit client #2 in the face with a pan - all allegations of abuse should be reported During interview on 9/1/21 the Quality Improvement Director reported: - HCPR informed in 1a fund and a separate investigation that FS#6 allegedly hit client #2 with a frying pan - the incident tageddy occurred in January 2021 - FS#6 was terminated in January 2021 due to				MHI 043-048	B. WING			
WOODHAVEN FAMILY CARE FACILITY (X4) ID SUMMARY STATEMENT OF DEPICIENCIES) PREFIX TAG (X4) ID PREFIX I SUMMARY STATEMENT OF DEPICIENCIES) PREFIX TAG (X5) ID PREFIX TAG (X6) ID PROFIX TAG (X6) ID PREFIX TAG (X6) ID PREFIX	ŀ			111112040 040			09/	02/2021
PREFIX TAG Continued From page 36 Their agency still had not received the investigation During interview on 8/24/21 staff #1 reported:				ITY 436 WEST	ROAD	STATE, ZIP CODE		
- their agency still had not received the investigation During interview on 8/24/21 staff #1 reported: - a year ago, she (staff #1) witnessed client #2 spit in FS#6 face - it happened so fast with client #2 having a behavior - FS#6 prepared dinner - FS#6 prepared dinner - FS#6 reacted by "accidentally" hitting client #2 in the face with the frying pan - there were no bruises to client #2's face - FS#6 said she would write up an incident report - she idid not report the incident to anybody because she thought FS#6 wrote an incident report - she informed a lady that worked for the State (HCPR) about the incident - did not recall the lady's name - management had not asked her about the incident During interview on 8/27/21 the Director of Operations/Qualified Professional (QP) reported: - she was not aware FS#6 allegedly hit client #2 in the face with a pan - all allegations of abuse should be reported During interview on 9/1/21 the Quality Improvement Director reported: - HCPR informed him 2 months ago during a separate investigation that FS#6 allegedly hit client #2 with a frying pan - the incident allegedly occurred in January 2021 - FS#6 was terminated in January 2021 due to		PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	(X5) COMPLETE DATE
broom - he asked staff #1 about the frying pan			- their agency still h investigation During interview on 8, - a year ago, she (s spit in FS#6's face - it happened so fas behavior - FS#6 prepared dir - FS#6 reacted by " #2 in the face with the - there were no brui - FS#6 said she wo report - she did not report because she thought report - she informed a lad (HCPR) about the inci - did not recall the lad - management had reincident During interview on 8/2 Operations/Qualified Preshe was not aware #2 in the face with a present all allegations of about the incident During interview on 9/1 Improvement Director - HCPR informed hir separate investigation client #2 with a frying present incident alleged 2021 - FS#6 was terminate another incident where broom	and not received the //24/21 staff #1 reported: staff #1) witnessed client #2 st with client #2 having a ner accidentally" hitting client e frying pan ises to client #2's face uld write up an incident the incident to anybody FS#6 wrote an incident ly that worked for the State dent ady's name not asked her about the //21 the Director of rofessional (QP) reported: FS#6 allegedly hit client an buse should be reported //21 the Quality reported: m 2 months ago during a that FS#6 allegedly hit ban fly occurred in January ed in January 2021 due to e she hit client #2 with a	V 132	In the future the Director of C Management will confirm the direction of any regulatory entask for a statement to support allegation or suggestion of the same. The Director of Quality Managwill monitor and track all allegand take steps immediately to ensure client protections and complete appropriate investigation.	tity and t any gement ations	

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V 132	Continued From page	e 37	V 132			
	client #2 but accidenta - there were no inju - staff #1 thought F3 report therefore she d incident - client #2 would not January 2021 - FS#6 was already could not be interview - HCPR representa this out to you." - she did not give cl incident had to be rep This deficiency is cross	S#6 completed an incident idn't tell anyone about the recall what happened terminated, therefore she red tive said "I'm just throwing lear information the orted to their agency as referenced into 10A mpetencies of Qualified sociate Professionals ule violation and must				
V 291	six clients when the clie developmental disabilit on June 15, 2001, and more than six clients at to provide services at n licensed capacity. (b) Service Coordination maintained between the qualified profession for treatment/habilitation (c) Participation of the Responsible Person. Ea	operations shall serve no more than ents have mental illness or ies. Any facility licensed providing services to that time, may continue to more than the facility's on. Coordination shall be the facility operator and hals who are responsible on or case management. Family or Legally	V 291			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED R B. WING MHL043-048 09/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **436 WEST ROAD** WOODHAVEN FAMILY CARE FACILITY CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 291 9/25/21 Continued From page 38 V 291 The facility will ensure coordination relationship with her or his family through such efforts with qualified professionals to means as visits to the facility and visits outside address all clients' treatment and the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the habilitation needs. legally responsible person of an adult resident. Reports may be in writing or take the form of a The Director of Operations will conference and shall focus on the client's facilitate contact with the Care progress toward meeting individual goals. (d) Coordinators to address client Program Activities. Each client shall have activity opportunities based on her/his choices. treatment or habilitation needs. needs and the treatment/habilitation plan. 9/25/21 Activities shall be designed to foster community The Director of Operations did inclusion. Choices may be limited when the schedule a team meeting, held on court or legal system is involved or when health or safety issues become a primary concern. 9/9/21 with client #1's quardian. care coordinator-amongst other staff to address her behavior challenges and habilitation needs. Client #1 9/25/21 This Rule is not met as evidenced by: was discharged effective 9/3/21. Based on observation, record review and interview the facility failed to coordinate with other qualified professionals who are The Director of Operations did responsible for 2 of 3 audited clients' (#1 & #2) schedule a team meeting, held on treatment/habilitation. The findings are: 914/21 with client #2's guardian, care coordinator amongst other staff A. Review on 8/25/21 of client #1's record revealed: to address her behavior challenges 9/25/21 admitted 7/16/20 and habilitation needs. Client #2's diagnoses of Autism, Intellectual behavior support plan was updated, Developmental Disorder (IDD), Bipolar, and her medication regimen was hearing loss, & nonverbal discussed. Observation on 8/13/21 between 1:42pm -1:49pm at the day program revealed: The Director of Operations will client #1 in the classroom with a 1:1 monitor the habilitation status of she smiled and waved clients weekly and consult with lower right eye was swollen, puffy, red and purple qualified professionals as needed to ensure continued compliance. Review on 8/27/21 of an incident report dated

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		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION G:	(X3) DATE	SURVEY	
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		out at 7am with a black the eye. I did have a sign her in the room the night transpired that could confall when I was trying to room but fell on her bath the eye was not set unot be left. During interview on 8/2 Operations/Qualified Poperations/Qualified Poperati	er room all night, came of eye as if she was hit in truggle with trying to get th before but nothing ause a black eye. She did to get her towards her of ck" written by staff #2 18/26/21 with staff #2: p and message could 15/21 the Director of rofessional (QP) & nt Director reported: what caused client #1's eye on was sought for client ement Director said the e cavity looked as if she rubbed of affect her vision #1 was nonverbal, she the eye if it hurt all background but elients f client #2's record ntellectual Disorder, Mood order, Schizoaffective eplosive Disorder, Type II & Methicillin-Resistant (MRSA) on 8/13/21 with client #2	V 291	In the future Client #1 or any or client with a related injury or mondition will be taken to the poare provider for direction on the injury to ensure appropriate assessment and treatment. The QP will coordinate these eand monitor in the home to ensure and monitor in the home to ensure and injury to ensure appropriate assessment and treatment. The QP will coordinate these eand monitor in the home to ensure appropriate assessment and treatment. The plan discharged from facility effective 9/3/21. The plan of protection remains effect currently.	other nedical orimary he efforts sure	9/25/21	

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	V 291	Continued From page	40	V 291				
		revealed:						
			#2's forehead covered with					
		a white bandage - spoke in broken se	ontonoo					
		- "get me out[clier						
		then pointed at her fore					1	
			on a shelf outside the front					
		office window at the ent	trance of the day program					
		Review on 8/27/21 of the	he facility's incident					
		report log regarding an	incident which occurred					
		at the day program reve						
			it may concern [client #1]					
			clock. [client #2] went to staff intervened" signed					1
		by the day program QP						1
	1	ay me any program ar						
	1	During interview on 8/3	0/21 client #2's Care					l
		Coordinator reported: - care coordinator si	noo Morob 2021					
			issues with client #2					
		getting along with her h						
		 if she was not getting 	ng along with housemates,					
		he would like to know						
			uld have happened to put					
		strategies in place	to increase monitoring					
		with additional staff	to increase monitoring					
		- he spoke with the D	Director of Operations/QP					
		on 8/17/21 to see how c	lient #2 was doing					
		 she informed him o 						ĺ
	- 1	being increased due to I						
		 he was concerned a additional staff were nea 	and asked if funds for					
			rations/QP said additional					
	1	funds were not needed						
		that filled in at the facility				Ì		
		During interview on 9/1/2						
_	(Operations/QP reported	:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 291	August 2021 - he informed her he assist with client #2 - she explained the shift - additional staff was During interview on 9/ Improvement Director - client #2's care conot understand her be - they would take as medication increase well- - the QP's kept the coordinators informed the clients - it was the QP's resignardians & care coordinators care This deficiency is cross	ient #2's care coordinator in the was looking into services 2's behaviors by have 2 people on 2nd this not discussed 1/21 the Quality treported: the ordinator was new and did the haviors dditional staff, however the twas needed guardians and care I about the care of the ordinators about the the services of Qualified the services of Qualified the services of Qualified the services of Qualified the ordinators and must the days.	V 291			
	implement written polici response to level I, II of shall require the providi (1) attending to the needs of individuals in	EMENTS FOR PROVIDERS (a) riders shall develop and cies governing their r III incidents. The policies ler to respond by: the health and safety				

MHL043-048 B. WING MHL043-048 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE 436 WEST ROAD CAMERON, NC 28326 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY TAG TO SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES OR SUMMARY STATEMENT OF DEFICIENCIES TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCEOT TO THE APPROPRIATE DEFICIENCY TAG TO SUMMARY STATEMENT OF DEFICIENCIES OR SUMMARY STATEMENT OF DEFICIENCIES TAG TO SUMMARY STATEMENT OF DEFICIENCIES OR SUMMARY STATEMENT OF DEFICIENCIES TAG TO SUMMARY STATEMENT OF DEFICIENCIES TAG TO SUMMARY STATEMENT OF DEFICIENCIES OR SUMMARY STATEMENT OF DEFICIENCIES TAG TO SUMMARY STATEMENT OF DEFICIENCIES TAG TO SUMMARY STATEMENT OF DEFICIENCIES OR SUMMARY STATEMENT OF DEFICIENCIES TAG TO SUMMARY STATEMENT OF DEFICIENCIES TAG TAG TO SUMMARY STAT	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETE		
WOODHAVEN FAMILY CARE FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 438 WEST ROAD CAMERON, NC 2836 SUMMARY STATEMENT OF DEFICIENCIES (FACH LIBERGE AND REPRESENDED BY FULL FREGULATORY OR IS DEHIFYING INFORMATION) V 366 Continued From page 42 (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CPF Parts 2 and 3 and 45 CPF Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule, (b) in addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICFMR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivening a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy sompleteness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team within 24 hours of the incident. The	MHL043-048			B. WING			
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CAMERON, NC 28326 International Commentaries CAMERON, NC 28326 International Camero, NC 28326 Inter	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
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(3) developing and implementing corrective measures according to provider specified timerfames not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timerfames not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) achering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the client is on the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider is detained and the premise and the premise and the provider's premises. The policies shall require the provider and the provider of the provider of the provider of the provider of the pr	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE C	COMPLETE
(3) developing and implementing corrective measures according to provider specified timerfames not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timerfames not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) achering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the client is on the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider is detained and the premise and the premise and the provider's premises. The policies shall require the provider and the provider of the provider of the provider of the provider of the pr	V 366	Continued From page	e 42	V 366			
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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY
		MHL043-048	B. WING		09/	R /02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIP CODE		OLI LOLI
Woonus		426 WEG	ST ROAD	E, 211 00DE		
WOODHA	VEN FAMILY CARE FACIL	.ITY	ON, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	were not responsible f with direct professional services at the time of review team shall composition follows: (A) review the condetermine the facts are and make recommend occurrence of future in (B) gather other (C) issue writter within five working day preliminary findings of LME in whose catchmolocated and to the LMI if different; and (D) issue a final the owner within three. The final report shall be whose catchment area and to the LME where different. The final writted the issues identified by shall include all public of incident, and shall make minimizing the occurrence all documents needed available within three may give the proventing the composition of the LME responsible within the submit (3) immediately (A) the LME responsible within the service to Rule .0604; (B) the LME when the fidifferent;	or the client's direct care or all oversight of the client's the incident. The internal plete all of the activities as opy of the client record to a causes of the incident dations for minimizing the cidents; information needed; preliminary findings of fact area the provider is the where the client resides, written report signed by months of the incident. The sent to the LME in the provider is located the client resides, if the internal review team, documents pertinent to the recommendations for an extension of up to the final report; and notifying the following: consible for the catchment are the client resides, are provided pursuant are the client resides,	V 366			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-048	B. WING		09/	R '02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	03/	02/2021	
WOODHA	VEN FAMILY CARE FACIL	436 WEST					
WOODIIA	VERT AMILT CATLET ACIE		N, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETE DATE	
V 366	Continued From page	44	V 366			9/25/21	
	provider; (D) the Departm (E) the client's leading applicable; and		. 335	The facility will ensure that all allegations of physical abuse investigated and reported thro IRIS per the facility policy.	are	0,20,21	
				The HCPR staff did not under circumstances suggest that the Quality Management Director complete an internal investigate. There is no email trail or written decrease that the complete state of the complete state of the complete state.	e tion. n	9/25/21	
	failed to implement the policy. The findings are Review on 8/20/21 of c	w and interview the facility ir own incident reporting		documentation from the HCPF suggest that this direction was given. In fact, there was no cle allegation of physical abuse th was inferred.	ar		
	Disorder, Psychotic Disorder, Intermittent E Diabetes, Hypertension	Explosive Disorder, Type II n & Methicillin-Resistant		In any event the Director of Que Management did initiate an IRI report and opened an investiga	S	9/25/21	
	that occurred at the fac	g details of the incident cility egedly hit client #2 in an		The staff who alleged to have the HCPR official indicated that did not share those specifics, sonly said it was an accident as was hit as she charged the staff was holding the pan	t she he client ff	9/25/21	
	Improvement Director he did not complete	reported:		it was an accident and not an allegation of physical abuse.			
	This deficiency is cross NCAC 27G .0203 Com Professionals and Asso (V109) for a type A1 ru be corrected within 23	petencies of Qualified ociate Professionals le violation and must		The investigation will comprise statement—and will be uploade IRIS. The Quality Management Director will monitor daily and address all allegations per police	ed to		

Division	Division of Health Service Regulation				roni	IVI AFFROVEL
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE :	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL	436 WES	T ROAD			
CAMERON, N		N, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 367	Continued From page	e 45	V 367			
V 367	27G .0604 Incident F	Reporting Requirements	V 367	•		
	level II incidents, exceduring the provision of the consumer is on the level III incidents and the clients to whom the service within 90 days LME responsible for the services are provided becoming aware of the besubmitted on a form Secretary. The report mail, in person, facsing means. The report shall information: (1) reporting providential information in the report shall information information in the report shall information in the report in the report information in the report	REMENTS FOR B PROVIDERS I providers shall report all ept deaths, that occur of billable services or while the providers premises or level II deaths involving the provider rendered any is prior to the incident to the the catchment area where within 72 hours of the incident. The report shall improvided by the may be submitted via the incident or encrypted electronic all include the following vider contact and				

any missing or incomplete information. The provider shall submit an updated report to all

or responding.

(3)

(4)

(5)

business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or

required report recipients by the end of the next

(b) Category A and B providers shall explain

type of incident;

the cause of the incident; and

description of incident;

status of the effort to determine

other individuals or authorities notified

(2) the provider obtains information required on the incident form that was previously

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		MHL043-048	B. WING		00	R (00/0004
NAME OF P	ROVIDER OR SUPPLIER		DDBESS CITY S	TATE, ZIP CODE	<u> </u>	/02/2021
		426 WES		TATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACILI		N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	confidential information (2) reports by ot (3) the provider's (d) Category A and B profile and all level III incident in Mental Health, Develop Substance Abuse Sendecoming aware of the providers shall send a incidents involving a clear Health Service Regula becoming aware of the death within seven day restraint, the provider simmediately, as required and 10A NCAC (e) Category A and B preport quarterly to the Latchment area where a The report shall be subby the Secretary via election include summary inform (1) medication enthe definition of a level (2) restrictive interthe definition of a level (3) searches of a (4) seizures of clicates (5) the total number (5) the total number (1) incidents that occurred (2) restrictive interthe the total number (5) the total number (6) the possession of a clicate (5) the total number (8) the course (9) the course (10) the possession of a clicate (10) the total number (11) the course (12) the total number (13) the course (14) the possession of a clicate (15) the total number (15) the course (15) the total number (15) the possession (15) the total number (15) the possession (15) the possession (15) the total number (15) the possession (15) the provider (15) the provide	providers shall submit, ME, other information incident, including: ords including on; her authorities; and is response to the incident. Providers shall send a copy eports to the Division of prenental Disabilities and prices within 72 hours of a incident. Category A copy of all level III itent death to the Division of the incident. In cases of client is of use of seclusion or shall report the death ed by 10A NCAC 26C 27E .0104(e)(18). To roviders shall send a lamber of the services are provided. The services are provided. The services are provided betronic means and shall mation as follows: The rors that do not meet all or level III incident; reventions that do not meet all or level III incident; client or his living area; ent property or property in ent; per of level II and level led; and dicating that there have dents whenever no	V 367			

MHL043-048 MHL043-048 MHL043-048 MHL043-048 MHL043-048 MIRON PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 438 WEST ROAD CAMERON, NC 28328 DEPROVIDER'S PLAN OF CORRECTION RECOLD BE CHOSS HETERACHOS RECOLD BE CHOSS HETERACHOS MEDICAL PROPERTY TAG WOODHAVEN FAMILY CARE FACILITY PRETEX ACCORDINATE STATES BY OF GEREISPORTS PARTY OF GEREISPORTS		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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Mail Date Mail Care Mail			426 WEST		TATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCES PRIEFICE PRIE	WOODHA	VEN FAMILY CARE FACILI	TY				
PREFIX TAG Continued From page 47 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a level II incident report was submitted to the LME/MCO (Local Management Entity and the Managed Care Organization) within 72 hours. The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Robod Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) Staphylococcus Aureus (MRSA) During interview on 9/1/21 the Quality Improvement Director reported: - he did not complete an incident report This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must	(V4) ID	SLIMMARY ST					
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(V109) for a type A1 rule violation and must reports to LME/MCO per policy		Professionals and Asset	petencies of Qualified				
50 001100104 WILLIII 20 4475.		be corrected within 23			reports to LIME/MCO per policy	.	

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		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
							R	
1			MHL043-048	B. WING		09/	02/2021	
l	NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
	WOODHAV	EN FAMILY CARE FACILI	TY	ST ROAD				
ŀ	(VA) ID	CLIMMADY CT		ON, NC 28326				
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
		10A NCAC 27D .0101 RESTRICTIONS AND (a) The governing bood that assures the imple 59, G.S. 122C-65, and (b) The governing bood and implement policy (1) all instances abuse, neglect or exploreported to the County Services as specified in G.S. 7A, Article 44; and (2) procedures a instituted in accordance practice when a medicipresent serious risk to Particular attention shaneuroleptic medications (c) In addition to those 10A NCAC 27E .0102(each facility shall deverthat identifies: (1) any restrictive prohibited from use with (2) in a 24-hour facunder which staff are put the rights of a client. (d) If the governing bod restrictive interventions facility, the restrictions of in G.S. 122C-62(b) and policy shall identify: (1) the permitted or allowed restrictions; (2) the individual reflection; and 3) the due process	INTERVENTIONS dy shall develop policy ementation of G.S. 122C- d G.S. 122C-66. dy shall develop to assure that: of alleged or suspected bitation of clients are Department of Social in G.S. 108A, Article 6 or d and safeguards are e with sound medical ation that is known to the client is prescribed. all be given to the use of s. procedures prohibited in 1), the governing body of lop and implement policy intervention that is nin the facility; and acility, the circumstances rohibited from restricting y allows the use of or if, in a 24-hour of client rights specified (d) are allowed, the restrictive interventions responsible for informing as procedures for an	V 500				
		nvoluntary client who re	riuses the use of	1				

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AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						R
		MHL043-048	B. WING		09/	02/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL					
			I, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETE DATE
V 500	Continued From page	49	V 500	The facility will ensure that all		9/25/21
	restrictive interventions (e) If restrictive interve within the facility, the g develop and implement compliance with Subch which includes: (1) the designat has been trained and y competence to use resprovide written authorize restrictive interventions is renewed for up to a accordance with the tir NCAC 27E .0104(e)(10 (2) the designative responsible for reviews interventions; and (3) the establish appeal for the resolution	s. Intions are allowed for use governing body shall at policy that assures mapter 27E, Section .0100, sion of an individual, who who has demonstrated strictive interventions, to zation for the use of swhen the original order total of 24 hours in the limits specified in 10A D)(E); on of an individual to be of the use of restrictive	V 500	allegations of physical abuse a reported to DSS. The HCPR staff did not under circumstances suggest that the Quality Management Director complete an internal investigat There is no email trail or writter documentation from the HCPR suggest that this direction was given. In fact, there was no clearliegation of physical abuse the was inferred. In any event the Director of Que Management did initiate a report of the property of the case in question.	any e ion. n to ar at	9/25/21
	failed to report allegatio audited clients (#2) to the Social Services (DSS). Review on 8/20/21 of client admitted 6/15/17 diagnoses of Mild In Disorder, Psychotic Disc	r and interview the facility ns of abuse for 1 of 3 ne County Department of The findings are: ient #2's record revealed: ntellectual Disorder, Mood order, Schizoaffective kplosive Disorder, Type II & Methicillin-Resistant (MRSA)		The staff who alleged to have to the HCPR official indicated that did not share those specifics, so only said it was an accident as was hit as she charged the staf while staff was holding the panit was an accident and not an allegation of physical abuse. DSS indicated that they will screout the case and send a letter to Provider. The Quality Managem Director will monitor daily and ensure that any allegation of abuse reported to DSS.	t she he client f and een o the nent use,	9/25/21

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-048	B. WING		R	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDDEED OITY O	TATE 710 CODE	09/02/2021	
		436 WES		STATE, ZIP CODE		
WOODHA	VEN FAMILY CARE FACIL	ITY	N, NC 28326			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 500	Continued From page	e 50	V 500			
		legedly hit client #2 in the				
	During interview on 9 Improvement Director he did not report t	reported:				
	NCAC 27G .0203 Cor Professionals and Ass	ule violation and must				
V 531	27E .0105(a) Client R	ights - Protective Devices	V 531			
	a client, the governing implement policy to er (1) the necessity has been assessed ar a facility employee wh has demonstrated conformative devices; (2) the use of posalternatives have been documented and the positive deviced appropriate mea (3) the client is free provided opportunities as needed. When a pro	ctive device is utilized for body shall develop and asure that: If or the protective device and the device is applied by to has been trained and appetence in the utilization sitive and less restrictive a reviewed and rotective device selected sure; equently observed and for toileting, exercise, etc. of other toileting, exercise, etc. of the total the ement, the client shall be a hour. Whenever the subject to injury by employee shall remain continuously.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(AS) DATE SU		SURVEY IPLETED	
	MHL043-048	B. WING		09/	R 02/2021
	CILITY 436 WES CAMERO STATEMENT OF DEFICIENCIES		STATE, ZIP CODE PROVIDER'S PLAN OF CORRECTION	037	(X5)
	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	COMPLETE DATE
at regular intervals (5) for facilitic contract with an aprotective devices plan shall be subjected in the subject of the subj	e devices are cleaned s; and es operated by or under rea program, the utilization of in the treatment/habilitation ect to review by the Client as required in 10A NCAC of this Rule and other published as Division as FOR MENTAL HEALTH, L DISABILITIES AND USE SERVICES, APSM 30-chased at a cost of five dollars ents (\$5.75) per copy. Let as evidenced by: Let as evidenced by:	V 531	The facility will ensure that protective devices are appropassessed before application to manage client behavior challe before implementation as such that staff are trained according such usage when applicable. The Psychologist did develop behavior support plan for client that incorporates the use of a protective helmet for self-injuri behavior. The BSP reflect contingent use of the protective device. The behavior analyst did in-seall assigned staff at the group and day program on Client #3' effective 9/23/21. The Director of Quality Manage will consult with qualified professionals and monitor any use of protective devices month ensure due process.	enges; h and gly on a at #3 ous e rvice home BSP ement	9/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL043-048	B. WING		09/	R 02/2021
	ROVIDER OR SUPPLIER VEN FAMILY CARE FACIL	TTY 436 WES	DDRESS, CITY, STATER OF TROAD ON, NC 28326	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 531	- client #3 had a he - a staff at the day #3 had a helmet at th - found the helmet closet at the facility - if she showed sigr would put the helmet - couldn't give time used the helmet - the straps on the h days ago - she did not know h - she tied the straps helmet on her head - the helmet calmed - a month ago she h head banging During interview on 9/ - worked at the facili - client #3 banged h get her way - no injuries - she (staff #5) put th - no one in manager the helmet on client #3 - client #3 does not l	Intervented: Imet due to head banging program informed her client e facility ast year in client #3's as of head banging she on frame of how often she helmet became loose a few now to tightened the straps together to keep the the head banging had to get stitches due to 1/21 staff #5 reported: ity for 2 weeks er head if she did not the helmet on her head ment requested she put ike to wear the helmet higher head when the helmet higher head when the helmet to her head when the helmet higher	V 531			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
		MHL043-048	B. WING OS		R 09/02/2021	
	ROVIDER OR SUPPLIER VEN FAMILY CARE FACIL	ITY 436 WE	ADDRESS, CITY, STA	TE, ZIP CODE		
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V 531	- it was not part of the helmet came in provider - the helmet should being a restrictive into a physician's order the helmet - it was not approve plan - the facility's envirous padding around chairs less intrusive - majority of staff we the facility a short per - there was not enough the helmet into a treat support plan During interview on 8/2 Operations/Qualified P - the helmet came was a previous placement - if client #3 had a b staff were to sit next to back and arm	ot be wearing a helmet her treatment plan with her from a previous I not be used due to it ervention er was needed to use ed in a behavior support onment was modified, as & recliner to make it ere new and only been at its do of time ugh data to incorporate ment plan or behavior 25/21 the Director of rofessional (QP) reported: with client #3 from ehavior of head banging, other & rub client #3's	V 531			
	27G .0303(c) Facility a 10A NCAC 27G .03 AND EXTERIOR REQ (c) Each facility and its maintained in a safe, cl orderly manner and sha offensive odor.	UIREMENTS grounds shall be lean, attractive and	V 736			

PRINTED: 09/17/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R B. WING MHL043-048 09/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 436 WEST ROAD WOODHAVEN FAMILY CARE FACILITY CAMERON, NC 28326 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) The QP/Residential Manager will V 736 Continued From page 54 9/25/21 V 736 conduct inspections 4-5 times weekly of the home to address cleanliness, odor, safe and orderly This Rule is not met as evidenced by: condition of the home and its Based on observation & interview the governing grounds. body failed to maintain the facility in a safe. clean, attractive and orderly manner and kept The QP/Residential Manager will free from offensive odor. The findings are: complete a maintenance request Observation on 8/13/21 between 12:45pm form to correct any issues noted. 9/25/21 - 1:00pm revealed the following: The Residential Manager will followtour of the facility given by the Quality up weekly on all maintenance Improvement Director request orders to determine the entrance of the home had a strong unidentified offensive odor status until corrected. facility filled with black gnats which covered the kitchen table & counter tops The plan of protection remains in effect as implemented by the QP. client #1's bedroom clothes covered the floor and bed All the issues were addressed after client #2's bedroom the initial visit by the state surveyor gnats covered the entire bedroom and there were 2 subsequent visits 9/25/21 the mattress hung off the bed by the state surveyor whereby, she clothes covered the bed, the floor and acknowledged significant the dresser bathroom had a strong offensive odor improvement in the condition of the several depends were filled with feces on home and its grounds. the bathroom floor the toilet was full of feces Residential Manager/QP will feces covered the outside of the toilet continue to monitor in the home 4-5 client #3's bedroom

strong smell of urine

depends on the client's dresser

there were clothes unfolded and folded spread out on the floor and dresser

Bathroom used by client #1 and client #3

the mattress had brown stains throughout

compliance.

times weekly to ensure continued

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE ZIP CODE] 09/	/02/2021	
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V 736	Continued From page	55	V 736				
		e floor which left an opened					
	- worked at the facility - clients slept during third shift staff could have to worry about be she had not seen to Operations/Qualified Proguality Improvement Distriction of the worked at the facility - worked as if the bear of the was a she was new & clies - when a sked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #2 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #42 liked certalisten when asked to cleaned in years - client #43 liked certalisten when asked to cleaned in years - client #43 liked certalisten when asked to cleaned in years - client #43 liked certalisten when asked to cleaned in years - client #43 liked certalisten when	g third shift ald mop, sweep and not alternative and mop, sweep and mop, and see and					
-	the facility client #2's bed was second shift was re						

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to the facility on 8/13/21 - staff had contacted pest control and was told	I							
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I noming could be done about dilats								
- pest control requested staff put vinegar all	-							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF			ATE SURVEY COMPLETED	
		MHL043-048	B. WING		I	R 0 2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
WOODHA	VEN FAMILY CARE FACIL	1/2/12/1					
WW 15	CHMMADVCT		N, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	BE ATE	(X5) COMPLETE DATE	
V 736	Continued From page	57	V 736			9/25/21	
	During interview on 8/ reported: - nothing could be of a facility probably had never heard to po to prevent gnats	done about gnats ad a drainage issue ur vinegar on the counters utes a re-cited deficiency s referenced into 10A upetencies of Qualified ociate Professionals le violation and must		The facility will conduct water temperature checks and ensu they are maintained between 116 degrees Fahrenheit. The Residential Manager/QP assume the responsible for inservice to staff and monitoring home and maintaining a copy water temperature checks in thome.	will in the of		
	visitors. (4) In areas of th are exposed to hot wate water shall be maintain degrees Fahrenheit. This Rule is not met as on observation, record	shall be designed, ped in a manner that afety of clients, staff and the facility where clients er, the temperature of the ed between 100-116 as evidenced by: Based review and interview the sure water temperatures een 100-116. The	V 752	The QP did in-service the staff water temperature checks, local of the thermometer in the home notification of variation outside the identified range. The QP wanddress any deviation to the required range and complete a order and contact maintenance adjustment to the water heater. The QP will review water temperature checks 4 times we in the home to ensure continue compliance.	ation e and of ill work e for	9/25/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			TE SURVEY OMPLETED	
MHL043-048		B. WING		05	R 0 /02/2021		
NAME OF PROVIDER OR S	UPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE		702/2021	
WOODHAVEN FAMILY	CADE EACH	436 WEST		, , , , , , , , , , , , , , , , , , , ,			
WOODHAVENTAWIET	CARE FACIL		N, NC 28326				
	CH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
1:00pm retemperature the kite sink water Review on temperature 7/3/21 8/27/2 During interest she converted the quarker temperature 1 the quarker temperature 2 the quarker temperature 3 the quarker temperature 2 the quarker temperature 3 the quarker 3 the	chen sink & temperature in 9/1/21 of the relog reveal of 103 at 1pth 1 - 110 at 7 terview on 9/1 erview on 9/1 eratures build not find peratures where the water the water the water the water the water the ensured the tored entity located ensure staff es daily lid check the ensure in a week ency is crossingly and Assatype A1 rule.	following water c clients' bathroom res were 128 degrees the facility's water aled: m :30pm /1/21 staff #1 reported: er temperatures the thermometer to check at was recently found essional (QP) ensured the ere checked 1/21 the Quality reported: nce was contacted to emperatures e water temperatures d the water thermometer at checked water e water temperatures s referenced into 10A mpetencies of Qualified ociate Professionals alle violation and must	V 752				



SEP 2 3 2021





Provider of MH/DD/SA Services

September 23, 2021

Ms. Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual Survey completed September 2, 2021 Woodhaven Family Care Facility 436 West Road, Cameron, NC 28326 MHL#043-048

Dear Ms. Smith:

See attached hard copy of the plan of correction (POC) for the Woodhaven Family Care Facility's annual, follow-up and complaint survey, completed 9/2/21. The POC represents our effort of credible actions to address the Type A1 citation. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact myself or Vidya Persad, Director of Operations. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James Harris, Director Quality Management