STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 25, 2018.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 1 of 2 sampled staff (Staff B, Supervisor-in-Charge), was screened for Tuberculosis (TB) upon hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired at the facility on 3/15/18 as a SIC. -There was documentation a TB skin test was administered on 2/19/18.	C 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 140	Continued From page 1 -There was no documention the TB skin test had been read. -There was no other documentation of any other TB skin test in the record. Interview on 4/26/18 at 1:30pm with the Administrator revealed: -She thought Staff B had been administered a TB skin test when she was hired. - The Licensed Health Professional Support Nurse (LHPS) "did the TB test" or they "could send the new staff member to the health department." -She had no documentation of a TB skin test read for Staff B. -She was responsible for making sure all new hire paperwork was complete. -She could not say why the TB skin test had not read and documented for Staff B. -She would have a TB skin test completed and read for Staff B as soon as possible. Interview on 4/26/18 at 2:20pm with Staff B revealed: -She had a TB skin test administered and thought she "was done with it". -"The nurse read it a couple of days later." -She recalled the facility nurse had given her a TB skin test and "came back and read it 12/23/17". Interview on 4/26/18 at 2:26pm with the LHPS Nurse revealed: -She administered the TB skin tests on all employees when they are hired. -She did not read the TB skin tests and had instructed the facility if there is any reaction to take a picture and send it to her. -She thought that she had given Staff B one TB skin test. -She had not read a TB skin test for Staff B.	C 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 140	Continued From page 2 -She had not been notified by Staff B of any reaction from her TB skin test.	C 140		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure a criminal background check was completed for 1 of 2 sampled staff (Staff A, Supervisor in Charge (SIC). The findings are: Review of Staff A's, personnel file revealed: -Staff A was hired as the SIC on 11/13/17. -There was no documentation a criminal background check had been completed as a condition of hire. -There was no documentation of a signed consent for a criminal background check. Interview on 4/26/18 at 1:20pm with Staff A, SIC revealed: -She had gone to the local county clerk of courts office and had a criminal background check completed when she was hired in November 2017. -She had the criminal background check in a folder she had at her home.	C 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 3 -She could not produce any documentation of a criminal background check prior to exit. Interview on 4/26/18 at 1:30pm with the Administrator revealed: -She was responsible for obtaining a criminal background check prior to employment. -She had hired Staff A without obtaining a criminal background check prior to employment. -"I failed to follow up." The facility failed to assure a criminal background check was obtained for Staff A, SIC prior to employment. The facilities failure of not knowing the criminal background history for Staff A was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 4/26/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 10, 2018.	C 147		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post a monthly activity calendar and assure a minimum of 14 hours per week for residents residing in the facility.	C 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 288	Continued From page 4 The findings are: Observation of the living room on 4/26/19 at 9:14am revealed: -There was an April 2018 calendar posted that contained outings for the month to the local parks ,grocery store and local department stores. -The April 2018 calendar posted with outings did not include any scheduled activities. -There were not 14 hours of scheduled activities on the April 2018 calendar. Interview with two of six residents during the initial facility tour on 4/26/18 revealed: -"I do my own thing, I will walk down to the store or do something." -"We just do stuff on our own." -"They did not do any scheduled activities." -"They have games but no one really wants to do them." Observation on 4/26/18 between 8:30am and 3:00pm revealed no activities were offered. Observation on 4/26/18 at 10:12am of the activity supplies in the dining room revealed: -There were books on a bookcase in the living room/dining room area. -There were 2 games were on top of a cabinet in the dining room. Interview with the Supervisor in Charge (SIC) on 4/26/18 at 3:10pm revealed: -She knew there was supposed to be 14 hours a week of planned activities offered. -She had spoken to the residents and knew what they wanted to do. -"I'm not going to make them do something they don't want to do, it's against their rights."	C 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 288	Continued From page 5 -"They don't like games and cards." -The residents preferred to do their own thing and occasionally they would watch a movie in the living room together. Interview with the Administrator on 4/26/18 at 3:15pm revealed: -She was responsible for the activity calendar. -She had not sent the activity calendar for the month to the SIC as it was still on her phone. -"I should have faxed the activity calendar" to the SIC so she would know what to offer. -The SIC was responsible for doing the activities in the facility. -She knew there was supposed to be 14 hours a week of planned activities.	C 288		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to a criminal background check. The findings are: Based on record review and interview, the facility failed to assure a criminal background check was	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 6 completed for 1 of 2 sampled staff (Staff A, Supervisor in Charge (SIC)). [Refer to Tag 0147, 10A NCAC 13G. .0406(a)(7) (Type B Violation)].	C 912		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C992	Continued From page 7 and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure examination and screening for the presence of controlled substance was completed for 1 of 2 sampled Staff A, Supervisor-in-Charge (SIC) prior to employment after 10/1/13. The findings are: Review of Staff A's personnel file revealed: -Staff A was hired as the Supervisor-in-Charge (SIC) with a hire date of 11/13/17. -There was no documentation of a consent for examination and screening for controlled substance. -There was no documentation an examination and screening for controlled substances had been completed as a condition of hire. Interview on 4/26/18 at 1:30pm with the Administrator revealed: -She was responsible for obtaining a signed consent for examination and screening for controlled substances from a potential employee. -She was responsible for ensuring the examination and screening for controlled substances was completed prior to an offer of employment. -She had hired Staff A without obtaining a consent for the examination and screening for controlled substances and without the required examination and screening for controlled substances. -She could not say why the screening had not been done.	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FCH # 2	32 SMITH GRAVEYARD RD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C992	Continued From page 8 -"I just missed it." -"I will do it right away." Interview on 4/26/18 at 2:24pm with Staff A, SIC, revealed: -She had not signed a consent for examination and screening for controlled substances for this facility. -She had not had an examination and screening for controlled substances as a condition of her employment. Observation on 4/26/18 at 1:53pm revealed: -The Administrator provided a home drug test to Staff A. -The Administrator reported to surveyor a negative results and provided the results on the lid top for review.	C992		