STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NOWIDEN.	A. BUILDING:					
MHL074-140		MHL074-140	B. WING			R 04/09/2019		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
WILLOW	MANOR		GREENVILLE ILLE, NC 278	BOULEVARD 358				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC 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 000	INITIAL COMMENTS		V 000					
		w-up survey was completed eficiencies were cited.						
		sed for the following service C 27G .1700 Residential cure for Children or						
V 118	27G .0209 (C) Medication Requirements		V 118					
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR							

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

(X6) DATE TITLE

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL074-140	B. WING		04/0	? 9/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE			
NAIVIL OI I	- NOVIDEN ON SOFFEIEN		, ,	BOULEVARD			
WILLOW	MANOR		LLE, NC 278				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	Continued From page 1		V 118				
	with a physician.						
	interview, the facility medications on the and failed to keep to of three audited clied. Review on 04/09/19 revealed: - 17 year old male Admission date of - Diagnoses of Opp Post Traumatic Street Hyperactivity Disord	view, observation and y failed to administer written order of a physician he MARs current affecting one ents (#1). The findings are: 9 of client #1's record 1 09/21/18. Positional Defiant Disorder, ess Disorder, Attention Deficit der and Bipolar Disorder.					
	for client #1 dated 0	9 of a signed physician order 09/21/18 revealed: nstipation) 17 grams in water -					
	revealed no transcr	o of client #1's April 2019 MAR ibed entry for Miralax and no ated the medication was dered.					
	- A bottle of Miralax	09/19 of client #1's roximately 10:36am revealed: labeled with client #1's name. minister 17 grams of Miralax in					
	Interview on 04/09/	19 client #1 stated he received					

STATE FORM 6899 If continuation sheet 2 of 4 RIWI11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL074-140		B. WING			R 04/09/2019	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
WILLOW MANOR 1419 SE GRE GREENVILLI				BOULEVARD 858		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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 118	Interview on 04/09/administering client had not documente Interview on 04/09/stated: - The pharmacy did client #1's April 201 - He would follow up on the MAR as order Due to the failure to medication adminis determined if the clias ordered by the p	19 staff #7 stated he had been #1's Miralax as ordered but d it on the MAR. 19 the Qualified Professional not transcribe the Miralax on 9 MAR. to to ensure medications were ered. 2 accurately document tration it could not be itent received their medication hysician.	V 118			
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor. This Rule is not me Based on observati was not maintained and orderly manner Observation on 04/65:00pm revealed th	I its grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: on and interviews, the facility in a safe, clean, attractive	V 736			

Division of Health Service Regulation STATE FORM

FORM 6899 RIWI11 If continuation sheet 3 of 4

Division of Health Service Regulation							
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL074-140		B. WING		R 04/09/2019			
					1 0-1/0	0,2010	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WILLOW MANOR			REENVILLE LLE, NC 278	E BOULEVARD 858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 736	Continued From page 3		V 736				
	every 35 seconds indicating it needed a battery replaced.						
	every 35 seconds indicating it needed a battery						

Division of Health Service Regulation STATE FORM

RIWI11 If continuation sheet 4 of 4