Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
			71. 501251110.		С				
		MHL005-024	B. WING		10/26/2021				
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE. ZIP CODE					
	603 LONG STREET								
WILLOW	WILLOW PLACE GROUP HOME WEST JEFFERSON, NC 28694								
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE				
V 000	00 INITIAL COMMENTS		V 000						
	on October 26, 2021. substantiated (Intake deficiency was cited. This facility is licensed	•							
V 290	Living for Individuals v		V 290						
	10A NCAC 27G .5602 (a) Staff-client ratios numbers specified in of this Rule shall be denable staff to responneeds. (b) A minimum of one present at all times who premises, except whe habilitation plan docur capable of remaining without supervision. as needed but not less the client continues to the home or communispecified periods of time (c) Staff shall be presented by the client continues to the home or communispecified periods of time (c) Staff shall be presented or adolescent cliented or adolescent cliented or adolescent clients present. How present during sleeping emergency back-up puthe governing body; or	2 STAFF above the minimum Paragraphs (b), (c) and (d) etermined by the facility to d to individualized client e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed s than annually to ensure be capable of remaining in ity without supervision for me. sent in a facility in the atios when more than one ent is present: adolescents with substance be served with a minimum or every five or fewer minor ever, only one staff need be ng hours if specified by the procedures determined by or							
	` '	adolescents with lities shall be served with							

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			(X3) DATE SURVEY COMPLETED		
MHL005-024		A. BUILDING:						
					C 0/ 26/2021			
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE				
		603 LON	G STREET					
WILLOW	PLACE GROUP HOME	WEST JE	FFERSON, NC 28	694				
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
V 290	present and two staff more clients present. need be present durin specified by the emer determined by the go (d) In facilities which diagnosis is substanc (1) at least one duty shall be trained i withdrawal symptoms secondary complicating drug addiction; and	every one to three clients present for every four or However, only one staff ng sleeping hours if gency back-up procedures verning body. serve clients whose primary e abuse dependency: staff member who is on n alcohol and other drug and symptoms of ons to alcohol and other s of a certified substance I be available on an	V 290					
	failed to ensure a min was present at all tim treatment plan docum capable of being with of 2 current clients (C deceased clients (DC Review on 8/18/21 of -Admission date: 8/15 -Diagnoses of Unspe Spectrum and other p Major Depressive d/o moderate; Alcohol Us Amphetamine-type su and Essential (primar Review on 8/18/21 of	ew and interviews the facility simum of one staff member es except when the client's nented that the client was out supervision affecting 2 lients #1 and #2) and 1 of 1 #3). The findings are: Client #1's record revealed: 6/19. cified Schizophrenia esychotic disorder (d/o); recurrent episode, de d/o, moderate; ubstance use d/o, severe; y) Hypertension.						

Division of Health Service Regulation

STATE FORM 6899 K6MB11 If continuation sheet 2 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		L COMPLE		
						C	
MHL005-024		B. WING	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	E, ZIP CODE			
MILL 0 M	DI ACE COCUDIUME	603 LON	G STREET				
WILLOW	PLACE GROUP HOME	WEST JE	FFERSON, NC 28	8694			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 290	Continued From page	2	V 290				
	dated 1/11/21 reveale	vd.					
		ouble focusing and getting					
	motivated to do things						
	-Ongoing and frequer						
	 Review on 8/18/21 of	Client #1's Individual					
		es dated 3/14/20 revealed:					
		supervised time, either in or					
out of the facility, but he seldom used it.							
	 Review on 8/19/21 of	an email dated 7/12/20					
		ofessional (QP)/Group					
		ding unsupervised time					
	revealed:						
	-Client #1 should have 4 hours of unsupervised						
	time in and outside of the facility.						
	Review on 8/18/21 of	Client #1's					
	Person-Centered Pro	file (PCP) dated 7/12/21					
	revealed:						
	-There were no goals or strategies addressing the						
	client's ability to be without supervision while in						
	and outside of the fac	ility.					
		with Client #1 revealed:					
		d time but he was not sure					
	how much.						
		upervised in the home.					
	-He did go for a walk	at times, but "not much."					
	 Review on 8/18/21 of	Client #2's record revealed:					
	-Admission date: 7/26						
	-Diagnoses of BiPola						
		s Disorder; and Intellectual					
	Developmental Delay						
	Review on 8/18/21 of						
		ment for Unsupervised					
		completed by the QP/Group					
	Home Manager revealed:						

Division of Health Service Regulation

STATE FORM 6899 K6MB11 If continuation sheet 3 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	, ,	(X3) DATE SURVEY COMPLETED		
ANDILAN			A. BUILDING: _	OOM! LETE	OOMI EETED		
				С			
		MHL005-024	B. WING		10/26/2	2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
\A/II O\A/	DI ACE COCUDIUME	603 LON	G STREET				
WILLOW	PLACE GROUP HOME	WEST JE	FFERSON, NC	28694			
(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 APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
V 290	Continued From page	3	V 290				
V 290	-Unsupervised time ir affecting in facility bei timeUnsupervised time ir -There were no signa Review on 8/19/21 of from Client #2's guard -She agreed with increase to 6 hours. Review on 8/18/21 of 8/13/20 revealed: -There were no goals client's ability to be with and outside of the facility and in the comes -She had 4 hours of a facility and in the comes -She did not use it all work and schoolWhen she used her firide her bike or take as	the facility - no concerns ng different from external a community - 4 hours. tures on the assessment. an email dated 6/16/21 dian revealed: easing the client's free time Client #2's PCP dated or strategies addressing the ithout supervision while in cility. with Client #2 revealed: unsupervised time in the insupervised time in the insupervis	V 290				
	-Deceased date 8/6/2 -Diagnoses of Major [11. Depressive d/o, recurrent					
	episode, moderate; u Borderline intellectual	nspecified Anxiety d/o;					
		eflux Disease; Gastritis;					
	Hypertension; Hiatal I	Hernia; Diabetes;					
		cholesterolemia; Irritable					
		eriosclerotic Cardiovascular					
	Disease; Hypothyroid						
	Gastroparesis; Colon	polyps and Hypogonadism.					
	Review on 8/18/21 of Clinical Assessment of	DC #3's most recent dated 2/2/21 revealed:					

Division of Health Service Regulation

STATE FORM 6899 K6MB11 If continuation sheet 4 of 6

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: _		COMPL			
						С		
	MHL005-024		B. WING			/26/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE	•			
NAME OF T	NOVIDEN ON 3011 EIEN	603 LONG		TIE, ZII GODE				
WILLOW	PLACE GROUP HOME		FERSON, NC	28694				
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETE DATE		
V 290	Continued From page	e 4	V 290					
	-He had moderate jud make decisions. -Supervised living, ps and individual therapy rehabilitation were red -There was no assess capability to be unsup community.	dgement in his ability to ychiatric services, group y and psychosocial commended. sment to address the client's pervised while in the						
Review on 8/18/21 of DC #3's PCP last updated 3/1/21 revealed: -There were no goals or strategies addressing the client's ability to be without supervision when in the community.								
	Review on 8/18/21 of an incident report in the NC Incident Response Improvement System revealed: -A level III incident for DC #3 dated 7/27/21. -DC #3 had an accident while driving his moped in town. -He was transported to a hospital where he later died on 8/6/21.							
	revealed: -She remembered dis Home Manager abou unsupervised time an approving itShe did not remembe conversation for via e -She had no authority moped or notShe felt it was a good client to have his indeed	d she remembered er if it was a verbal mail. whether the client rode his d thing as this allowed the ependence.						
revealed: -Based on her discussions with the detective and								

Division of Health Service Regulation

STATE FORM 6899 K6MB11 If continuation sheet 5 of 6

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER WILLOW PLACE GROUP HOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING: B. WING CO 10/26/202 STREET ADDRESS, CITY, STATE, ZIP CODE 603 LONG STREET WEST JEFFERSON, NC 28694	STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI		
NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER WILLOW PLACE GROUP HOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 603 LONG STREET WEST JEFFERSON, NC 28694 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE) COM	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	: IED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WILLOW PLACE GROUP HOME 603 LONG STREET WEST JEFFERSON, NC 28694 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			R WING		_			
WILLOW PLACE GROUP HOME 603 LONG STREET WEST JEFFERSON, NC 28694 (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	MHL005-024			D. WING		10/2	6/2021	
WILLOW PLACE GROUP HOME WEST JEFFERSON, NC 28694 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	NAME OF PE	OF PROVIDER OR SUPPLIER			TE, ZIP CODE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	WILLOW F	W PLACE GROUP HOME						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			WEST JEF	FERSON, NC	28694			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	(X5) COMPLETE DATE	
V 290 Continued From page 5 V 290	V 290	290 Continued From page	e 5	V 290				
the physician's the client had a brain bleed and this was what caused the accident. -She paid to have the client's moped fixed; He had it for a long time, this was what the always did and he looked forward to riding it. -This was how he kept some independence and she was very supportive of this. -She remembered talking with the QP/Group Home Manager and guardian about the client having unsupervised time and she was in agreement with this. Interview on 8/19/21 with the QP/Group Home Manager revealed: -He was a part of the team developing the PCP for clients along with the clinical care home teamHe signed the PCP once the official copy was in the facilityDC #3 did not have an unsupervised time assessment and it was not in his PCP; "He [DC #3] did not have one-but he should have." -DC #3 was local and knew areas around town better than he didUsually he liked to have 30 days to evaluate the client, talk with staff and to the team before making the decision of allowing unsupervised timeThe PCP can be created in their electronic record system now; this was a new systemHe searched for unsupervised time in Client #1 and Client #2's PCP and did not find thisHe was aware if a client was allowed unsupervised time, either in or outside of the facility, it needed to be in the client's PCPHe ensured staff was aware of client's with unsupervised time during staff meetings once a month and they were also to sign the Individual Specific Competeptencies for each client which	V 290	the physician's the clithis was what caused -She paid to have the had it for a long time, and he looked forwar -This was how he key she was very support -She remembered tal Home Manager and ghaving unsupervised agreement with this. Interview on 8/19/21 Manager revealed: -He was a part of the for clients along with -He signed the PCP of the facilityDC #3 did not have assessment and it wa #3] did not have one-DC #3 was local and better than he didUsually he liked to he client, talk with staff a making the decision of timeThe PCP can be cre record system now; the searched for uns and Client #2's PCP are record system in a client #2's PCP are record system in a client #2's PCP are record system in a client #2's PCP are record staff was unsupervised time, eif facility, it needed to be -He ensured staff was unsupervised time du month and they were	ient had a brain bleed and a the accident. Is client's moped fixed; He this was what he always did at to riding it. In the some independence and tive of this. Is liking with the QP/Group guardian about the client time and she was in With the QP/Group Home It cam developing the PCP the clinical care home team. Sonce the official copy was in an unsupervised time as not in his PCP; "He [DC shut he should have." If knew areas around town It was allowed in their electronic his was a new system. Supervised time in Client #1 and did not find this. It ient was allowed ither in or outside of the in the client's PCP. It is aware of client's with uring staff meetings once a stafe of sign the Individual	V 290				

Division of Health Service Regulation

STATE FORM 6899 K6MB11 If continuation sheet 6 of 6