	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY LETED
		MHL007-088	B. WING		03/0	7/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3644 CHF	RRY ROAD			
COUNTR	Y LIVING WILLOW H	WASHING	STON, NC 2	7889		
(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 000	INITIAL COMMENT	-s	V 000			
	An annual survey w 2024. A deficiency v	ras completed on March 7, was cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
		sed for 6 beds and currently The survey sample consisted nt clients.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person and drugs. (2) Medications shat clients only when and client's physician. (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered administered in Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be y licensed persons, or by trained by a registered nurse, regally qualified person and e and administer medications. ministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug;				
<u></u>		ne drug is administered; and of person administering the				

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

(X6) DATE TITLE

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL007-088	B. WING		03/	07/2024
	PROVIDER OR SUPPLIER RY LIVING WILLOW H	OUSE 3644 CH	DDRESS, CITY, S'IERRY ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	(5) Client requests checks shall be rec	ge 1 for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	facility failed to admordered by the phys	views and interviews, the ninister medications as sician and maintain accurate rrent clients (clients #1, #2 and	d			
	revealed: - 64 year old female - Admission date of - Diagnoses of Den Disturbance, Mode Developmental Dis Developmental Dis Hypothyroidism, Ar Compulsive Disord	11/13/23. hentia with Behavioral rate Intellectual ability (IDD), Pervasive order, Hypertension, exiety Disorder and Obsessive er (OCD).				
	physician orders re 02/22/24 - Abilify (antipsycho 1/2 tablet (2.5mg) a 11/14/23 - Atorvastatin (lowe one at bedtime.	tic) 5 milligrams (mg) - take				

Division of Health Service Regulation

DIVISION	Division of Health Service Regulation						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL007-088	B. WING		03/0	7/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
COUNT		3644 CHI	RRY ROAD				
COUNTR	RY LIVING WILLOW H	WASHING	STON, NC 27	7889			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 2	V 118				
	daily Hydralazine (treat take three times da - Metformin (treats tablets at bedtime Refresh Plus 0.5% instill 2 drops into ri - Topiramate (treats tablets twice daily Trazodone (antide take 1/2 tablet at bedtime	s high blood pressure) 25mg - ily. blood sugar) 500mg - take 2 6 eye drops (eye lubrication) - ght eye at bedtime. 6 seizures) 200mg - take 2 6 pressant/sleep aid) 50mg - edtime. 7 of client #1's January 2024 MARs revealed: 7 taff initials to indicate 1/07/24 and 01/16/24. 7 staff initials to indicate 1/07/24 and 01/16/24 at 8pm. 7 taff initials to indicate 1/07/24 and 01/16/24 at 8pm. 7 initials to indicate 1/07/24 and 01/16/24. 7 s - no staff initials to indicate 1/07/24 and 01/16/24. 7 aff initials to indicate 1/07/24 and 02/29/24 at 8pm. 7 taff initials to indicate 1/2/21/24 and 02/29/24 at 8pm. 7 taff initials to indicate 1/2/21/24 and 02/29/24 at 8pm. 7 taff initials to indicate 1/2/21/24 and 02/29/24 at 8pm. 7 taff initials to indicate 1/2/21/24 and 02/29/24 at 8pm. 7 taff initials to indicate 1/2/21/24 and 02/29/24 at 8pm.					

Division of Health Service Regulation

administration on 02/21/24 and 02/29/24.

STATE FORM S9GI11 If continuation sheet 3 of 7

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MHL007-088		B. WING		03/0	07/2024
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COUNT	RY LIVING WILLOW H	OUSE		RRY ROAD STON, NC 27	7889		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From paragraph of the paragrap	is - no staff initials to 2/21/24 and 02/29/24 client #1 stated ations daily as order at of client #2's recorded at of client #2's signature and a certification and a certification at a certif	24. te 24 at 8pm. se 24. she ered. rd ted lar and ed ke 1 tablet g - take 1 take once instill 2 17 grams in uary 2024	V 118			

Division of Health Service Regulation

STATE FORM S9GI11 If continuation sheet 4 of 7

ווטופועום	of Health Service Re	guiation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
,	0. 00		A. BUILDING:				
		MHL007-088	B. WING		03/0	7/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COUNTE	RY LIVING WILLOW H	OUSE 3644 CHE	RRY ROAD				
	CI EIVIITO WIELOW II	WASHING	STON, NC 27	7889			
(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 APPROF	D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 4	V 118				
	administration on 0 - Simvastatin - no s administration on 0	taff initials to indicate					
	administration on 0: - Flonase - no staff administration on 0: - Polyethylene Glyc administration on 0: - Risperidone - no stadministration on 0: at 8am Simvastatin - no stadministration on 0:	initials to indicate 2/29/24. ol - no staff initials to indicate 2/29/24. staff initials to indicate 2/21/24 at 8pm and 02/29/24 aff initials to indicate 2/21/24.					
	Interview on 03/06/2 received her medic	24 client #2 indicated she ations daily.					
	revealed: - 57 year old female - Admission date of - Diagnoses of Mild	01/03/24. IDD, Diabetes, Depression, ess Disorder, Hyperlipidemia					
	dated 12/19/23 revelorders: - Colesevelam (treatake 1 tablet 3 time - Dicyclomine (treatake 1 tablet twice conduction - Duloxetine (treatake)	s functional bowel) 20mg - daily. depression) 30mg - take once restless leg syndrome) 1mg -					

Division of Health Service Regulation

STATE FORM S9GI11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL007-088	B. WING		03/	07/2024
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
COUNTR	RY LIVING WILLOW H	IOUSE	CHERRY ROAD IINGTON, NC 2	7889		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	age 5	V 118			
	February MARs rev January 2024 - Colesevam - no s administration on 0 noon and 5pm and - Dicyclomine - no s administration on 0 01/04/24 at 5pm. - Duloxetine - no st administration on 0 February 2024 - Colesevam - no s	staff initials to indicate 11/01/24 and 01/02/24 at 12 01/04/24 at 5pm. staff initials to indicate 11/01/24, 01/02/24 and staff initials to indicate				
	noon Duloxetine - no st administration on 0 - Ropinirole - no sta	raff initials to indicate 12/21/24 and 02/29/24. aff initials to indicate 12/21/24 and 02/29/24. aff initials to indicate 12/21/24 and 02/29/24.				
	(RN)/Associate Pro - Clients received the - She had reviewed - She had addresse		n			
	Professional stated - Clients received the r	'24 the RN/Qualified I: heir medications as ordered requently inserviced on nedication administration. o accurately document stration, it could not be				
		s received their medications	:			

Division of Health Service Regulation

STATE FORM S9GI11 If continuation sheet 6 of 7

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: COMPLETED A. BUILDING: _____ B. WING _ MHL007-088 03/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3644 CHERRY ROAD COUNTRY LIVING WILLOW HOUSE** WASHINGTON NC 27889

WASHINGTON, NC 27889							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			

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