STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL005-024 NAME OF PROVIDER OR SUPPLIER STREET A			(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED R 07/03/2024	
		B. WING				
		DDRESS, CITY, STATE,		01/03/2024		
			IG STREET	, 0002		
ILLOW F	PLACE GROUP HOME		EFFERSON, NC 28	694		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on July 3, 2024. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
	-	d for 6 and has a current vey sample consisted of ents.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	 only be administered order of a person auti drugs. (2) Medications shall clients only when auti client's physician. (3) Medications, inclu administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the 	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be v after administration. The following: nd quantity of the drug;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL005-024					(X3) DATE SURVEY COMPLETED	
		BERTH IOTHOUTOWBEN.				
		B. WING		07	R 07/03/2024	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	PLACE GROUP HOME		IG STREET EFFERSON, NC 28	694		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 1		V 118			
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation				
	failed to ensure medi only by licensed pers persons trained by a or other legally qualif	as evidenced by: nd record review, the facility cations were administered ons, or by unlicensed registered nurse, pharmacist ied person affecting 2 of 3 I and #2). The findings are:				
	revealed: -Hire date: 6/15/20. -Position: Direct Supp	Staff #1's personnel record port Professional (DSP). ration training dated 6/16/20.				
	-Hire date: 6/8/22. -Position: Direct Supp	Staff #2's record revealed: port Professional (DSP). ration training dated 6/14/22.				
	shift. -Medication administr completed virtually w -"never done a med	ations to the clients while on ration training was ith the facility's RN. dication administration				
	training in person with Interviews on 7/2/24 revealed: alth Service Regulation	h the nurse (RN)." and 7/3/24 with Staff #2				

STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL005-024			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		B. WING		R 07/03/2024			
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	PLACE GROUP HOME		IG STREET				
		WEST J	EFFERSON, NC 28	694			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From page	e 2	V 118				
	-Administered medications to the clients while on						
	shift.						
	-Completed medication administration training						
	every 2 years.						
	-Medication administration training was						
	completed virtually with the facility's RN.						
	-No part of the medication administration training						
	was completed in-person, completed "all on						
	[virtual training vendor]."						
	-"She (RN) goes through the process and there is a 30-question test at the end."						
	-The Qualified Professional (QP) observed her						
	administer medications to the clients after						
	completion of the medication administration						
	training.						
	Interviews on 7/1/24 and 7/2/24 with the QP						
	revealed:						
	-The facility used to have a different RN who						
	completed medication administration training in person (since 2019).						
		ration training "has mostly					
	been virtual since Co						
		component for medication					
		re not nurses or physicians."					
		ional staff and himself					
	"observed med (me	edication) pass (medication					
		least 3 med passes before					
	staff can give meds."						
	Interview on 7/2/24 w	vith the facility's RN revealed:					
		see since late September					
	2023.						
	-Medication administration training was						
	completed virtually "no hands-on piece to it."						
		o pass 2 written tests with at					
		o successfully complete the					
		ation training offered by the					
	facility.	up at the facility was a surface t					
	-No in-person follow	up at the facility was required					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL005-024						(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		B. WING		07	R 07/03/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
WILLOW	PLACE GROUP HOME		IG STREET EFFERSON, NC 286	594			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From page 3		V 118				
	completed by staff. -"haven't done any (administration) obse (facility) didn't need it -Would ensure staff of medication administra sure they (staff) are p staff during the virtua training)have to pas watching." -Medication administra offered in-person bed hundreds of staffwo get to everyoneon n everyone is trained." Interview on 7/3/24 w revealed: -Was responsible for to staff. -Medication administra completed virtually w -Was not sure whose medication administra not know." -"been with the age and had been doing i here." -It was the "manage direct support staff to -The RNs were "no person medication ad classroom training) u	rvations thereWillow Place "competency during virtual ation training by "making baying attention (monitored I medication administration as the quiz with myself ration training was not cause "one of me and buld be quite a lot to try to myself to make sure with the Residential Director sending training reminders ration training was ith the RN. decision it was to make the ation trainings virtual "I do ency (Licensee) for 2 years t that way since I've been er's responsibility with the observe med passes." t doing any follow up (with in dministration after the virtual nless there is an issue i ssue identified by the					

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