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: \_ R MHL005-024 B. WING 07/03/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **603 LONG STREET** WILLOW PLACE GROUP HOME WEST JEFFERSON, NC 28694 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients. 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 RECEIVED clients only when authorized in writing by the client's physician. AUG 07 2024 (3) Medications, including injections, shall be administered only by licensed persons, or by **DHSR-MH Licensure Sect** 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:

drug. Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(D) date and time the drug is administered; and (E) name or initials of person administering the

eslis Flowers, Snr. QM Director

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E	COMPLETED				
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	FATE, ZIP CODE					
WILLOW	PLACE GROUP HOME	603 LONG	STREET						
WEST JEFFERSON, NC 28694									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPR DEFICIENCY)	BE COMPLETE				
V 118	Continued From page	2	V 118						
V 118	-Administered medical shiftCompleted medication every 2 yearsMedication administration completed virtually with a substantial was completed in-persure [virtual training vendor] -"She (RN) goes through a 30-question test at the substantial training vendor] -The Qualified Profess administer medication completion of the meditarining.  Interviews on 7/1/24 and revealed: -The facility used to has completed medication person (since 2019)Medication administration we are substantial since Covider administration	tions to the clients while on n administration training ation training was he the facility's RN. tion administration training son, completed "all on]." gh the process and there is ne end." ional (QP) observed her is to the clients after ication administration and 7/2/24 with the QP  ave a different RN who administration training inhas mostly d." omponent for medication not nurses or physicians."	V 118						
	-Worked for the license 2023Medication administra completed virtually "n -Staff were required to least an 80% score to smedication administratifacility.	e since late September tion training was							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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		MHL005-024	B. WING		07/03/2024				
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WILLOW PLACE GROUP HOME 603 LONG STREET									
WEST JEFFERSON, NC 28694  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)									
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE				
V 118	Continued From page 3		V 118						
	after the medication administration training was completed by staff"haven't done any medication pass (administration) observations thereWillow Place (facility) didn't need it." -Would ensure staff competency during virtual								
	medication administra sure they (staff) are pa staff during the virtual training)have to pass watching."	tion training by "making aying attention (monitored medication administration s the quiz with myself							
	-Medication administra offered in-person beca hundreds of staffwou get to everyoneon m everyone is trained."	ause "one of me and uld be quite a lot to try to							
	revealed: -Was responsible for set to staffMedication administrate completed virtually with -Was not sure whose of medication administrate not know." -"been with the agent and had been doing it there."	the RN.  decision it was to make the decision trainings virtual "I do decision trainings virtual ".							
	direct support staff to o -The RNs were "not of	doing any follow up (with in ninistration after the virtual ess there is an issue ssue identified by the							

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