

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL074-274</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BROWN'S PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2409 RHINESTONE DRIVE WINTERVILLE, NC 28590</b>
--	---

(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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on November 14, 2024. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence.</p> <p>This facility is licensed for 1 and has a current census of 1. The survey sample consisted of an audit of 1 current client.</p>	V 000		
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the</p>	V 118		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL074-274</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BROWN'S PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2409 RHINESTONE DRIVE WINTERVILLE, NC 28590</b>
--	---

(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
V 118	<p>Continued From page 1</p> <p>drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff who administered client medications were trained by a legally qualified and privileged person who could prepare and administer medications. The findings are:</p> <p>Review on 11/14/24 staff #1 personnel record revealed: -Hire date: 5/11/21. -No documentation of medication administration training completed.</p> <p>Review on 11/14/24 staff #2 personnel record revealed: -Hire date: 7/26/22. -No documentation of medication administration training completed.</p> <p>Interview on 11/14/24 staff #1 stated: -She had been licensed for 2 years. -She had completed medication administration training with a Registered Nurse.</p> <p>Interview on 11/14/24 staff #2 stated: -Stated she worked with client #1 on Saturdays. -She had completed medication administration training with a Registered Nurse.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL074-274</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BROWN'S PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2409 RHINESTONE DRIVE WINTERVILLE, NC 28590</b>
--	---

(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
V 118	Continued From page 2  Interview on 11/14/24 Qualified Professional stated: -She was unable to access the medication administration training documentation. -"Human Resources puts current employee's files away and they can not be accessed at this time." -She would ensure that the all training verification was accessible from this point on.	V 118		