STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL020-033	A. BUILDING: _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HALLS OF UNAKA #1	14949-A JOE BROWN HIGHWAY MURPHY, NC 28906

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V 000	INITIAL COMMENTS An annual survey was completed on September 13, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to develop and implement strategies to meet the treatment needs for 1 of 3 audited clients (#3). The findings are: Record review on 9/10/18 for Client #3 revealed: -Admitted on 10/31/08 with diagnoses of Disruptive Behavior Disorder, Moderate Mental Retardation, hypothyroidism, Cerebral Palsy, and gait problems. -Consultation from for treatment dated 1/18/17 indicated the weight for Client #3 was 113. -Consultation form for treatment dated 8/16/18 indicated the weight for Client #3 was 90. -Consultation form for treatment dated 7/13/18 indicated a nasal fracture. -Consultation form for treatment dated 8/30/18 indicated a third metacarpal fracture. Review on 9/10/18 of the treatment plan for Client #3 revealed that the treatment plan had not been updated to include the weight loss and increase in falls for Client #3. Interview on 9/11/18 with the Physician's Assistant revealed: -She had recommended dietary changes on 8/16/18 and monitoring of his weight. -She indicated that the weight loss for Client #3 needed further exploration. -She also discussed the recent fractures, nose and hand, for Client #3. She had treated Client #3 for the fractures and referred him to the specialists he needed to see. Interviews on 9/11/18 and 9/13/18 with the Director revealed: -She had not updated the treatment plan for	V 112		

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V 112	Continued From page 2 Client #3. -He was experiencing increased falls and had been to multiple physician appointments. -The facility monitored him closely for falls and at meal time. Efforts were made to increase his food intake although they now had to serve him soft and chopped foods. -Client #3 was not gaining weight and the physician had been consulted. -The increased falls and weight loss were relatively new for Client #3 and it had not registered with her that she needed to update the treatment plan. -She indicated that she gets busy with all the clients and issues like that do not always cross her mind.	V 112		
V 118	27G .0209 (C) Medication Requirements 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 clients only when authorized in writing by the client's physician. (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. (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:	V 118		

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V 118	Continued From page 3 (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to obtain written authorization from a physician for the self-administration of a medication for 2 of 3 audited clients (#1, #3) and failed to ensure MARs were current for 2 of 3 audited clients (#1, #2). The findings are: Record review on 9/10/18 for Client #1 revealed: -Admitted on 2/3/17 with diagnoses of hypertension, hyperlipidemia, Peripheral vascular disease, Diabetes, Traumatic Brain Injury, Moderate Intellectual Disabilities and Schizophrenia. -Physician orders dated 1/22/18 for Pentoxifylline 400mg three times daily, Gabapentin 600mg, 1 at bedtime, and Melatonin 3mg, 1 at bedtime. -No physician's order to self-administer the noon dose of Pentoxifylline 400mg. Review on 9/10/18 of the July 2018-September 2018 MARs for Client #1 revealed: -The 8:00PM doses of Pentoxifylline, Gabapentin, and Melatonin were pre-charted on 9/10/18.	V 118		

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V 118	Continued From page 4 Record review on 9/10/18 for Client #2 revealed: -Admitted on 9/4/09 with diagnoses of hyperlipidemia, Diabetes, hypertension, Peripheral Neuropathy, gastro esophageal reflux disease, Moderate Intellectual Disability, Schizophrenia and Bi-Polar Disorder. -Physician's order dated 1/31/18 for Gabapentin 300mg, 1 at bedtime. -Physician's order dated 2/18/18 for Risperidone 4mg, ½ in the morning and 1 at bedtime. -Physician's order dated 9/6/18 for Cephalexin 500mg, 1 every 12 hours for 10 days. Observation at 11:43AM on 9/10/18 of the medications for Client #2 revealed: -Cephalexin 500mg was dispensed on 9/6/18. Tablets were counted and it was determined that the medication had been given to date as ordered. Review on 9/10/18 of the July 2018-September 2018 MARs for Client #2 revealed: -The 8:00PM doses of Gabapentin and Risperidone were pre-charted on 9/10/18. -The Cephalexin was not added to the September MAR and administration of the medication was not documented. Record review on 9/10/18 for Client #3 revealed: -Admitted on 10/31/08 with diagnoses of Disruptive Behavior Disorder, Moderate Mental Retardation, hypothyroidism, Cerebral Palsy, and gait problems. -Physician's orders dated 2/12/18 for Tizanidine 4mg, 1 three times daily as needed and Lorazepam 1mg, 1 three times daily. -No physician's orders to self-administer the noon doses of Tizanidine and Lorazepam.	V 118		

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V 118	Continued From page 5 Interviews on 9/11/18 and 9/13/18 with the Director revealed: -She managed the oversight of medication administration. -She updated MARs as changes occurred. -Every 6 months she reviewed the records to ensure all physician orders were on hand. She reviewed medications with the physician at each medical visit. -For the clients who took noon medications she put the noon tablet in a pharmacy labeled bottle and sent it with the client to self-administer at noon. -She did not realize that she needed an order from the physician to self-administer the noon only dose. -She forgot to add the new medication for Client #2 to the September MAR but had administered the medication as ordered. -The pre-charting that occurred on 9/10/18 for several medications was simply an oversight and must have occurred when she charted the morning medication.	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall	V 367		

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V 367	Continued From page 6 be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of	V 367		

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V 367	Continued From page 7 Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Level III incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident effecting 1 of 3 audited clients (#3). The findings are: Record review on 9/10/18 for Client #3 revealed: -Admitted on 10/31/08 with diagnoses of	V 367		

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V 367	Continued From page 8 Disruptive Behavior Disorder, Moderate Mental Retardation, hypothyroidism, Cerebral Palsy, and gait problems. -Consultation form for treatment by Primary Care Physician and Ear Nose and Throat Specialist dated 7/13/18 indicated a nasal fracture. -Consultation form for treatment by Primary Care Physician dated 8/30/18 indicated a third metacarpal fracture. -Follow up documentation in the record of treatment provided by a local Orthopedist. This documentation indicated a "Closed fracture of shaft of metacarpal bone ...placed into a cheater cast ..." Review on 9/10/18 of incident reports from 7/2018-9/2018 revealed: -On 7/13/18 " ...[Client #3] was acting out by pitching a fit. He was throwing himself around ...fell so much that staff thought his nose was broken ...Bloodwork, cat scan and x-rays completed ...appointment with ENT (ear, nose, throat) specialist today ..." Incident documentation entered into IRIS but not fully submitted. Review on 9/10/18 of the incident reports in IRIS (Incident Reporting Improvement System) revealed that no Level II incident reports had been submitted. Interviews on 9/11/18 and 9/13/18 with the Director revealed: -She indicated that Client #3 came into the room one night and showed her his swollen and bruised hand. He had not complained of pain at all prior to that time and had not indicated the he had been hurt. She administered Tylenol and an ice pack and took him to the primary care physician first thing the next morning. He was	V 367		

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V 367	Continued From page 9 then referred to an Orthopedist. She was not aware of exactly what may have occurred in order for him to obtain the injury. -She fully believed that she submitted the incident on 7/13/18 into IRIS. She indicated that she had a follow up discussion with the LME-MCO as a result. -Because she was not aware of exactly how Client #3 obtained a fracture in his hand she did not enter the information into IRIS. She was not aware that she needed to do that. -She indicated that due to the remote location of the facility she experienced frequent connectivity issues with the internet. She further added when she entered the data into IRIS for the incident on 7/13/18 she got kicked out several times.	V 367		