STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL020034	A. BUILDING: _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HALLS OF UNAKA #2	14949-B JOE BROWN HIGHWAY MURPHY, NC 28906

(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	INITIAL COMMENTS An annual survey was completed on September 13, 2018. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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: (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.	V 118		

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V 118	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure medications were administered as ordered, and failed to ensure MARs were current for 1 of 3 audited clients (#1). The findings are: Record review on 9/11/18 for Client #1 revealed: -Admission date of 12/15/06 with diagnoses of Cerebral Palsy, Epilepsy, Personality Disorder, and Borderline Intellectual Functioning. Observation on 9/10/18 at 3:27PM of the medications for Client #1 revealed: -Carbamzepine 200mg (seizures) tablets dispensed on 8/16/18. -Phenytoin 100mg (seizures) tablets dispensed on 9/2/18. Review on 9/10/18 of the physician orders for Client #1 revealed: -Physician's order dated 5/7/18 for Phenytoin, 100mg Monday and Friday and 200mg Sunday, Tuesday, Wednesday, Thursday and Saturday. -Physician's order dated 7/17/18 for an increase in Phenytoin to 200mg daily. Lab work ordered on this date also noted in the documentation by the physician. Note in record documented by the facility indicated that the physician's office called the facility on 7/25/18 and advised the facility to implement the 200mg daily dose that was signed by the PA (Physician's Assistant) on 7/17/18. -Physician's order dated 8/16/18 to increase the Phenytoin to 300mg daily. -Physician's order dated 4/16/18 for	V 118		

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V 118	Continued From page 2	V 118		

Carbamazepine 200mg three times daily.
-Physician's order dated 7/25/18 to decrease Carbamazepine 200mg to twice daily.
-Physician's order dated 8/16/18 to increase the Carbamazepine 200mg back up to three times daily and then this medication was again reduced to twice daily on 8/30/18.

Review on 9/10/18 of the July 2018-September 2018 MARs for Client #1 revealed:
-Phenytoin administration continued at the original dose until 8/16/18 when the dose was increased to 300mg daily. The 300mg dose of Phenytoin was administered as 100mg three times daily.
-Phenytoin was not increased to the interim dose of 200mg daily as ordered for late July and early August.
-Carbamazepine increase to three times daily that was ordered on 8/16/18 was only documented as administered from 8/16/18-8/20/18. From 8/21/18-8/29/18 the Carbamazepine was only documented twice daily.
-The directions for administration of Phenytoin on the September MAR indicated that Phenytoin was to be administered "three tablets daily by mouth 8/16/18 new order". The Phenytoin 100mg was charted twice daily.
-Due to the failure to accurately document medication administration for Client #1, it could not be determined if he received the Phenytoin and Carbamazepine as ordered by the physician.

Review on 9/11/18 of the "Seizure Tracker" for Client #1 revealed:
-June 2018 2 seizures, July 2018 3 seizures, August 2018 2 seizures, and 0 for September 2018.

Interview on 9/10/18 with Client #1 revealed:

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V 118	Continued From page 3 -He received his medications daily and was taken to his medical appointments by the facility staff. -He stated that he thought his medication for the seizures had been increased. -He indicated that his seizures had improved. Interviews on 9/11/18 and 9/12/18 with the Physician's Assistant for Client #1 revealed: -The lower the Phenytoin level the higher the risk for seizures. -She indicated that the drop in the Phenytoin level could be the result of the amount of protein he consumed, interactions with other drugs and how the drug is absorbed into his blood stream. She added that his level had been stable but that the high level of Carbamazepine could have been related to the drop in Phenytoin. -The normal level of Phenytoin should be between 10 and 20. -The Phenytoin levels for Client #1 were 2.5 on 7/17/18, 1.7 on 8/15/18 and 16 on 8/30/18. -There would have been an increase in the Phenytoin level if the 200mg daily dose had been implemented. -She indicated that Client #1's level of Phenytoin was lower than the therapeutic range and if the 200mg dose increase was not implemented then he "stayed 2 weeks longer at the sub-therapeutic range". -She indicated that if his seizures did not double or triple and remained "relatively stable" then there was no harm. She added that 2-3 seizures was the baseline for Client #1. -"It is better to be in a therapeutic range." -She stated that because Client #1 stayed in a sub-therapeutic range for a shorter time frame there was less risk to him and that the risk would have been greater if he had gone longer at the lower dose. -Levels were now normal.	V 118		

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V 118	Continued From page 4 -She indicated that as long as Client #1 received 300mg daily there was no problem administering the 100mg tablet three times per day. She stated that maintenance doses could be divided. Interview on 9/11/18 with Staff #1 revealed: -He indicated that he and the Director administered the medications for Client #1. -He indicated that he remembered the increase to 200mg of Phenytoin for Client #1 and that they gave that dose increase and then increased the medication again to the 300mg dose. Interviews on 9/11/18 and 9/13/18 with the Director revealed: -Medications were administered by either her or her husband. -She was responsible for the oversight of medication administration. -She updated the MARs as needed and when changes occurred. -She reviewed the records every 6 months to make sure she had physician orders for all medications. -She reviewed each client's medications with the PA at each medical appointment. -She indicated that she had implemented the increase of Phenytoin to 200mg in July. -She stated that she remembered having the discussion with the PA in July about increasing the Phenytoin and decreasing the Carbamazepine. She indicated that she had made the error on the MAR but felt that Client #1 had received the medication correctly. -She stated that she administered the 300mg of Phenytoin in three separate does and thought that administration was correct. She stated that in September she was giving Client #1 300mg but forgot to put the noon dose on the MAR. -She stated that there were a lot of changes all at	V 118		

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V 118	Continued From page 5 once for Client #1 and it was "a lot to keep up with". -She indicated that she tried "really hard" to keep her records in order but that she does make mistakes. Review on 9/13/18 of the Plan of Protection signed and dated by the Director on 9/13/18 revealed: -What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "Fix medication administration record for the consumer that has issue immediately. Review all MARs with orders weekly. Call Doctor's office with any changes in medications and always get clarity if unsure-immediately. When medication change occurs add new medication sheet immediately." -Describe your plans to make sure the above happens: "Start immediately to review all MARs on consumers weekly. This would include reviewing meds and orders from physicians. If something is unclear call dr. office and get clarity. Document as well. Have nurse or other trained staff in medication administration double check medications within the next week. Have nurse complete refresher course with director within a week." Client #1 is diagnosed with Epilepsy and prescribed two medications for the control of his seizures. When a low Phenytoin level was discovered by his medical provider in July, changes were made to his medication regimen in order to increase the Phenytoin level back to normal. The facility failed to implement the initial increase of Phenytoin ordered in July and failed to accurately document the administration of his	V 118		

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V 118	Continued From page 6 seizure medication. Client #1's Phenytoin level dropped slightly lower than the already low level determined on 7/17/18. At the end of August his Phenytoin level was back to normal, however, Client #1 remained in a sub-therapeutic range for Phenytoin longer than the physician intended which put him at an increased risk for greater seizure activity which was detrimental to his health and safety. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118		