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 _____	12/18/2019

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 12/18/19. 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		

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 _____	12/18/2019

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 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to update strategies in the treatment plans to reflect the current needs of the clients effecting 2 of 3 sampled clients (Client's #2 and #3). The findings are: Record review on 12/18/19 for Client #2 revealed: -Admitted on 6/1/04. -diagnoses of Seizures, Diabetes Mellitus- insulin dependent, Gastroesophageal Reflux Disease, Hypertension, Disruptive Behavior Disorder, moderate Intellectual Developmental Disorder, Chronic Kidney Disease, and Intermittent Explosive Disorder. -Physician orders dated 10/8/19 included Buspirone 15 mg, 1 - 3 times a day. -signed physician's authorization dated 4/18/19 for the client to self-administer his medications. Review on 12/18/19 of Client #2's treatment plan last revised 4/29/19 revealed: -no strategies regarding the client's ability to self-administer his medications. Interview on 12/17/19 with Client #2 revealed: -he took medication while he was at the day program, but did not know what he took. -the Director got out the medications he was to take. Review on 12/18/19 of Client #3's record revealed: -Admitted 3/18/11. -diagnoses of Depression, Mild Anxiety, Mild Intellectual Developmental Disability, Diabetes Mellitus Type II, Acid Reflux, Allergies, and Obesity. -Physician orders dated 10/16/19 included	V 112		

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 _____	12/18/2019

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 112	Continued From page 2 Hydroxyzine 25 mg, 1 - 2 times a day, and 2 at bedtime. -signed physician's authorization dated 9/30/19 for the client to self-administer his medications. Review on 12/18/19 of Client #3's treatment plan last revised 8/28/19 revealed: -no strategies regarding the client's ability to self-administer his medication. Interview on 12/17/19 with Client #3 revealed: -he took medications at the day program, but had "no idea" what they were. -his medications were already packed and his worker made sure he took them. Interview on 12/18/19 with the Qualified Professional/Director revealed: -for the client's who took medications at the day program she received empty bottles with the labels on them from the pharmacy. -she packed each bottle with the medication the client was to take while at the day program and put it in their lunch bags. -their worker at the day program made sure the client's took all the medications she packed during lunch. -she checked the bottles when the client's returned to the facility to ensure the medications were taken.	V 112		