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 _____	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HALLS OF UNAKA #1	14949-A 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 and follow-up 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		

DHSR - Mental Health
JAN 3 2020
Lic. & Cert. Section

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V 112	Continued From page 1	V 112		

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 #1 and #3). The findings are:

Record review on 12/18/19 for Client #1 revealed:
-Admitted on 9/4/09.
-diagnoses of Borderline Intellectual Functioning, Hyperlipidema, Diabetes Mellitus Type II, Hypertension, Peripheral Neuropathy, Gastroesophageal Reflux Disease, and Schizophrenia-Paranoid Type.
-Physician orders dated 10/8/19 included Ferrous Sulfate 325 mg, 1-3 times a day; Divalproex Sodium Dr 250 mg, 1- 4 times a day, and Gabapentin 100 mg 1 at 8:00 a.m., 1 at 2:00 p.m. and 2 at bedtime.
-signed physician's authorization dated 10/8/19 for the client to self-administer her medications.

Review on 12/18/19 of Client #1's treatment plan last revised 9/17/19 revealed:
-a strategy to provide support for medication administration as she could not administer her medications correctly.

Interview on 12/17/19 with Client #1 revealed:
-she took medication while she was at the day program.
-she took an iron pill, a sleeping pill, and a white tablet - 3 pills at lunch.

Review on 12/18/19 of Client #3's record revealed:
-Admitted 2/3/17.
-diagnoses of Hypertension, Hyperlipidemia, Peripheral Vascular Disease, Schizophrenia,

What:

All clients who take medications while away from the facility will have an addendum added to their service plan. While away indicates while at their day program/workshop. The addendum will specify that trained medication staff will ensure the correct dose of each medication will go into client's medication bottle for the lunch dose or dose while away on a daily basis. When new service plans are completed, this will be added to the medication goal in order to specify the procedure for lunch/day doses while away.

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V 112	Continued From page 2 Traumatic Brain Injury, and Moderate Intellectual Developmental Disability. -Physician orders dated 11/19/19 included Hydralazine 25 mg, 1- 4 times a day; Divalproex Sodium Dr 125 mg, 1- 3 times a day, and Pentoxifylline ER 400 mg, 1 - 3 times a day, 7:00 a.m., 12 noon, and 8:00 p.m. -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 5/11/19 revealed: -a strategy that he needed reminders, coaching, and supervision. -he required prompting to take his medications as prescribed and to have a qualified staff administer to ensure he took all of 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. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112	Prevention: It will be reviewed Annually with service plans reviews to ensure it does not happen again. who: The director/ QP will monitor to ensure this is part of the service plan on an annual bases. How often: Annually	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118	Continued From page 3	V 118		

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.

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure medications were administered as ordered for 1 of 3 audited clients (Client #1). The findings are:

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V 118	Continued From page 4	V 118		

Record review on 12/17/19 for Client #1 revealed:
-Admitted on 9/4/09.
-diagnoses of Borderline Intellectual Functioning, Hyperlipidema, Diabetes Mellitus Type II, Hypertension, Peripheral Neuropathy, Gastroesophageal Reflux Disease, and Schizophrenia-Paranoid Type.
-Physician's order dated 10/9/19 and updated 11/20/19 Gabapentin 100 mg - 1 at 8:00 a.m., 1 at 2:00 p.m., and 2 at bedtime.

Observation on 12/17/19 at approximately 2:30 p.m. of Client #1's medications included:
-Gabapentin 100 mg - 1 at 8:00 a.m., 1 at 2:00 p.m., 2 at bedtime.

Review on 12/17/19 and 12/18/19 of the Medication Administration Records (MARs) for October 2019 through December 17, 2019 revealed:
-October - a handwritten note Gabapentin 100 mg changed to 1 at 8:00 a.m., 1 at 2:00 p.m. and 2 at bedtime.
-November - Gabapentin 100 mg - 1 every 6 hours as needed.
-December - Gabapentin 100 mg - 1 at 8:00 a.m., 1 at 2:00 p.m., 1 at bedtime.

Interview on 12/18/19 with the Qualified Professional/Director revealed:
-the pharmacy continually put the wrong label on the bottles.
-the medication was written wrong on the MAR.
-she reconciled the medications every month to ensure they matched the physician's orders.
-the client was receiving one Gabapentin at night so far in December as "this is what the sheet says."

This deficiency constitutes a re-cited deficiency

What:
When a prescription comes in for the month from the pharmacy, the staff putting medications away will compare old label, new label, order and medication administration record. If there is a difference in any of these, contact & question pharmacy, have last script faxed. If there is still a question, contact prescribing physician.

Prevent:
Take all steps noted above and continue to check medications on a monthly basis.

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V 118	Continued From page 5 and must be corrected within 30 days.	V 118		

Who:
The director/QP-BS will monitor this situation.

How Often:
The Director/QP-BS will continue to monitor monthly.