STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-959	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WITH AUTISM 2	7401 DENLEE ROAD RALEIGH, NC 27606

(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 was completed on 8/4/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-959	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WITH AUTISM 2	7401 DENLEE ROAD RALEIGH, NC 27606

(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 113	Continued From page 1 (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a complete record for 1 of 3 clients (#2). The findings are: Review on 08/05/22 of client #2's facility record revealed: - Admitted: 6/15/19 - Diagnoses: Autism, Anxiety, Gerd and Seizure Disorder - No Consent forms, including emergency information and the consent for emergency care and treatment information was blank with no client name and no client information Interview on 08/02/22 the Director stated: - The qualified professional should have completed these consents before the guardian signed.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-959	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WITH AUTISM 2	7401 DENLEE ROAD RALEIGH, NC 27606

(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 113	Continued From page 2 - She would have to ensure the consents are filled out completely	V 113		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-959	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WITH AUTISM 2	7401 DENLEE ROAD RALEIGH, NC 27606

(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 3 This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to administer medications as prescribed for 1 of 3 audited clients (#3). The findings are: Review on 8/2/22 of client #3's record revealed: - Admitted: 6/15/21 - Diagnoses: Autism, Moderate Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder(ADHD) Review on 8/2/22 of client #2 Physician orders dated 7/19/22 revealed: - Focalin 35mg capsule (Take one capsule by mouth in the morning)(used for ADHD) - Clonidine 2 mg (Take two tablets by mouth every evening)(used for hypertension) Observation on 8/2/22 at 2:30pm of client #2's medication bin revealed: -No Focalin present -No Clonidine present Interview on 8/2/22 the Director stated: - Waiting for medicaid to pay for the medication - Should have had the medication or a note from the physician - She would ensure this doesn't happen again	V 118		