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 _____	R 07/24/2023

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 and follow up survey was completed on July 24, 2023. 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 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.	V 118		

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V 118	Continued From page 1 (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 2 of 3 audited clients (#2 & #3) administered medications on the written order of a physician. The findings are: A. Review on 7/21/23 of client #2's record revealed: - admitted 6/15/21 - diagnoses: Autism & Moderate Intellectual Developmental Disorder - physician's order dated: 5/31/23 - Tizanidine 2mg 2 by mouth daily (muscle spasms) Review on 7/21/23 of client #2's June 2023 & July 2023 MAR revealed: - June 2023 MAR 3 PO daily - July 2023 MAR: the 2 was marked through and someone transcribed a 3 PO daily Observation on 7/21/23 at 11:27am of client #2's medication revealed: - Tizanidine had 2 pills in the bubble pack During interview on 7/21/23 the facility's Qualified Professional (QP) reported: - he was in the facility 2 - 3 times a week - he checked medications when he was at the facility	V 118		

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V 118	Continued From page 2 - would review the June & July 2023 MAR for the Tizanidine documentation error During interview on 7/21/23 the Director reported: - she contacted the pharmacy - the order for Tizanidine was received 5/31/23 - a staff transcribed the June & July 2023 MAR for Tizanidine incorrectly - client #3 no longer needed Metformin because he was no longer considered pre-diabetic B. Review on 7/21/23 of client #3's record revealed: - admitted 3/6/23 - diagnoses: Schizophrenia, Autism, & Intellectual Developmental Disability - no physician's order or discontinue order for Metformin HCL 500mg take 1 by mouth twice a day with meals (Diabetes) Observation on 7/21/23 at 10:15am of client #3's medications revealed: - Metformin 500mg in the bubble pack During interview on 7/21/23 the facility's Qualified Professional (QP) reported: - client #3's Metformin was discontinued when he first came to the facility - the Director should have the physician's order to discontinue Metformin During interview on 7/21/23 the Director reported: - client #3 no longer needed Metformin because he was no longer considered pre-diabetic - the Metformin was discontinued when client #3 was admitted on 3/6/23 - the pharmacy was in the process of sending the physician's orders for the Metformin	V 118		

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V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure medications were disposed of in a manner that guarded against diversion or accidental ingestion for 2 of 3	V 119		

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V 119	Continued From page 4 audited clients (#1 & #3). The findings are: A. Review on 7/21/23 of client #1's record revealed: - admitted 4/6/18 - diagnoses of Autism, Impulse Disorder & Nonverbal - physician order dated 2/11/23: Hydroxyzine 25mg as needed Observation on 7/21/23 at 11am of client #1's medications revealed: - Hydroxyzine medication label: discard after 4/12/23 During interview on 7/21/23 the Director reported: - she checked the client medication bins once a month for medications that needed to be disposed of - she overlooked the Hydroxyzine B. Review on 7/21/23 of client #3's record revealed: - admitted 3/6/23 - diagnoses: Schizophrenia, Autism, & Intellectual Developmental Disability - no physician's order for Metformin HCL 500mg take 1 by mouth twice a day with meals (Diabetes) - physician's order dated 6/29/23: Diazepam 10 mg take 1 by mouth at bedtime (Anxiety) - physician's order dated 2/23/23: Cetirizine HCL 10mg take 1 tab by mouth daily (Allergies) Observation on 7/21/23 of client #3's medication revealed: - a plastic bag containing a bubble pack with 1 Diazepam 10mg and 1 Metformin 500mg inside Observation on 7/21/23 at 1:09pm of medicine	V 119		

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V 119	Continued From page 5	V 119		

inside a plastic bag that was kept at the day program revealed:
- 2 Cetirizine HCL 10mg
- 2 Metformin 500mg
- 2 Diazepam 10 mg

During interview on 7/21/23 staff #1 reported:
- the facility started using bubble packs "a couple of days ago"
- he knew the medicine in the bubble packs were wrong so he administered client #3's medicine out of the old pill packs
- he gave discarded medication to the Director

During interview on 7/21/23 staff #2 reported:
- client #3 no longer took Metformin and his Diazepam changed
- the two pills were included in the bubble packs
- she did not administer the two pills and gave them to the Director
- she knew the medications were supposed to be sent back to the pharmacy

During interview on 7/21/23 the Qualified Professional (QP) reported:
- he checked the medications when he's in the facility
- he was aware of staff removing the pills from the bubble pack
- he discarded unused medications every Friday
- he was aware the Director had medicine that needed to be discarded

During interview on 7/21/23 the Director reported:
- staff administered the Cetirizine from the old pill pack instead of the new bubble pack
- client #3's Metformin was discontinued when he was admitted on 3/6/23

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V 119	Continued From page 6 - the physician changed client #3's Diazepam to once a day at night - the pharmacy included the Metformin and the morning dose of Diazepam in the bubble pack - she instructed staff to remove the Metformin and morning dose of Diazepam out of the bubble pack prior to administering - she kept the medicine in her locker at the day program and she planned to discard them	V 119		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation & interview the facility failed to maintain the water temperatures between 100-116 degrees Fahrenheit. The findings are: Observation on 7/21/23 at 10:41am revealed: - the temperature of the sink in client #3's bathroom was 90 degrees Fahrenheit - the temperature of the sink located in the kitchen was 90 degrees Fahrenheit - the temperature of the sink in the bathroom located in the hallway was 90 degrees Fahrenheit During interview on 7/21/23 the Director reported:	V 752		

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V 752	Continued From page 7 - she was responsible for checking the water temperatures in the facility and she checked it monthly - she used a digital thermometer but the thermometer was broken - "it worked a couple of weeks ago" - she did not document her water temperature checks	V 752		