Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		MHL020034	B. WING		03/2	5/2025						
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE CORED TO THE APPROPRIATE							
V 000	INITIAL COMMENT	-S	V 000									
	An annual survey w deficiency was cited	ras completed on 3/25/25. A										
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.											
		ed for 6 and has a current urvey sample consisted of an ients.										
V 121	27G .0209 (F) Medi	cation Requirements	V 121									
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.											
	facility failed to obta physician's review of	et as evidenced by: views and interviews, the nin a pharmacist's or of medications every 6 months ients (#2, #3). The findings										

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14949-B JOE BROWN HIGHWAY 14949-B JOE BROWN HIGHWAY MURPHY, NC 2896 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFER TAG SUMMARY STATEMENT OF DEFICIENCIES RECOLLATION OR LISC DESTIFYMIC INFORMATION) V 121 Continued From page 1 Record review on 3/25/25 for Client #2 revealed: -Date of admission-10/11/03Diagnoses- Severe Intellectual Developmental Disability (IDD), Anxiety Disorder, Schizophrenia, Autism, Anxiety Disorder, Type II DiabetesPhysician ordered medications dated 5/13/24 included: -Clozapine 100mg (milligram) (schizophrenia) -3 tablets (tabs) daily in the morning and 2 tabs daily in the eveningThe last drug review was completed on 5/15/24. There was no documentation to indicate a pharmacist or physician had provided a 6 month review of medications ordered 4/18/24; -Buspirone 10mg (anxiety) - 1 tab daily in the morning, ½ tab dally at lunch, 1 tab daily at bedtimeAnipiprazole 5mg (depression) - 1 tab daily in the morning, ½ tab dally at lunch, 1 tab daily at bedtimeThe last drug review was completed on 5/9/24. There was no documentation to indicate a pharmacist or physician had provided a 6 month review of medications ordered 4/18/24; -Buspirone 10mg (anxiety) - 1 tab daily in the morning, ½ tab dally at lunch, 1 tab daily at bedtimeThe last drug review was completed on 5/9/24. There was no documentation to indicate a pharmacist or physician had provided a 6 month review of medications for Client #2. Interview on 3/24/25 with the Director/Qualified Professional revealed: -Previously completed the 6-month drug reviews but someone told her it wash't requiredWould have the drug reviews completed by the client's prescriber immediately.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED						
AUTUMN HALLS OF UNAKA #2 MURPHY, NC 2996 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG			MHL020034	B. WING		03/2	25/2025						
Display Disp	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 121 Continued From page 1 Record review on 3/25/25 for Client #2 revealed: -Date of admission-10/11/03Diagnoses- Severe Intellectual Developmental Disability (IDD), Anxiety Disorder, Schizophrenia, Autism, Anxiety Disorder, Type II DiabetesPhysician ordered medications dated 5/13/24 included: -Clozapine 100mg (milligram) (schizophrenia) -3 tablets (tabs) daily in the morning and 2 tabs daily in the eveningThe last drug review was completed on 5/15/24. There was no documentation to indicate a pharmacist or physician had provided a 6 month review of medications for Client #3 revealed: -Date of admission-6/6/23Diagnoses- Mild IDD, Seizure Disorder, Anxiety Disorder, Major Depressive Disorder, -Physician ordered medications ordered 4/18/24: -Buspirone 10mg (anxiety) - 1 tab daily in the morning, ½ tab daily at lunch, 1 tab daily at becttimeAntipirazole 5mg (depression) - 1 tab daily, -Trazadone 50mg (sleep) - 2 tabs daily at becttimeThe last drug review was completed on 5/9/24. There was no documentation to indicate a pharmacist or physician had provided a 6 month review of medications for Client #2. Interview on 3/24/25 with the Director/Qualified Professional revealed: -Previously completed the 6-month drug reviews but someone told her it wasn't requiredWould have the drug reviews completed by the	AUTUMN HALLS OF UNAKA #2												
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	V 121	Record review on 3 -Date of admissionDiagnoses- Severe Disability (IDD), And Autism, Anxiety Dis -Physician ordered included: -Clozapine 100 -3 tablets (tabs) dai daily in the evening -The last drug revie There was no docu pharmacist or phys review of medicatio Record review on 3 -Date of admissionDiagnoses- Mild ID Disorder, Major De -Physician ordered -Buspirone 10n morning, ½ tab dail bedtimeAripiprazole 5n -Trazadone 50n bedtimeThe last drug revie There was no docu pharmacist or phys review of medicatio Interview on 3/24/29 Professional reveal -Previously complet but someone told h -Would have the dr	in/25/25 for Client #2 revealed: -10/11/03. In Intellectual Developmental exicty Disorder, Schizophrenia, forder, Type II Diabetes. Intellectual Developmental exicty Disorder, Schizophrenia, forder, Type II Diabetes. Intellectual Developmental exicty Disorder, Schizophrenia, forder, Type II Diabetes. Intellectual Disorder and 2 tabs Intellectual exict and intellectual exict and and provided a 6 month exict and provided a 6 month exict and provided a 6 month exict and provider. Intellectual exict and provided a 6 month exict and provided a 6 month exict and (anxiety) - 1 tab daily in the exict and (anxiety) - 2 tabs daily at exict and provided a 6 month exict and provided a 6	V 121									

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