STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-158	A. BUILDING: _____ B. WING _____	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING WAY 104	104 CARING WAY SHELBY, NC 28150

(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 May 8, 2018. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	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. (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		

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V 118	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure drugs administered to a client on written order of a person authorized to prescribe drugs affecting 1 of 3 clients (Client #2). The findings are: Review on 5/8/18 of Client #2's record revealed: Admission date: 2/20/18 Diagnoses: Severe Mental Retardation, Pervasive Developmental Disorder-Not Otherwise Specified, Obsessive Compulsive Disorder -Physician's order in 2/2018 for Fluvoxamine Maleate 100 milligrams, take 1 tablet twice daily -Client #2's April 2018 MAR revealed: -Fluvoxamine Maleate medication (used to treat Obsessive Compulsive Disorder) was not administered to client at the 7:00 am dosage times on 4/10/18 and 4/11/18 and at the 7:00 pm dosage time on 4/10/18 because the facility was out of the medication; -Medication consent form signed by Client #2's guardian on 2/20/18 authorized the facility to administer Client #2's prescribed medications; -Client #2 was out of the facility 16 of 30 days during April 2018 and not administered medication by staff. Review of facility incident reports from January 2018-May 2018 revealed Client #2 missed 3 doses of his prescribed medication in a 2 day period: -4/10/18 at 7:30 am (initial incident report) revealed: -The facility was out of Client #2's Fluvoxamine	V 118		

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V 118	Continued From page 2 Maleate medication and Client #2 was not administered the medication; -Client #2 was administered one dose of Fluvoxamine Maleate on 4/9/18 at 7:00 pm; -Client #2 returned from a home visit the afternoon of 4/9/18 with one Fluvoxamine Maleate tablet; -Client #2's guardian was contacted about client's need for refill on the aforementioned medication; -Client #2's guardian and facility were working to have Client #2's medications changed to another local pharmacy; -Client #2's physician was not contacted by staff about client's refill of the Fluvoxamine Maleate; -4/10/18 at 7:00 pm (second incident report) revealed: -Client #2's Fluvoxamine Maleate was still not at the facility and Client #2 missed his second medication dose; -Client #2's guardian was contacted about status of Client #2's medication refill; -Client #2's physician was notified by staff about Client #2's medication refill need but there was no documentation of the physician's response to the situation; -4/11/18 at 7:00 am (third incident report) revealed: -Client #2 missed his morning dose of Fluvoxamine Maleate because the facility was still out of the medication; -Client #2's physician was not contacted about Client #2's need for medication refill of the Fluvoxamine Maleate; -Client #2's guardian was contacted about the client's need for the medication refill; -Client #2 received refill on his Fluvoxamine Maleate and was administered his 7:00 pm medication dose.	V 118		

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V 118	Continued From page 3 Review on 5/8/18 of the facility's Medication Requirements Policy revealed: -A statement that "It is ultimately the responsibility of all members of the daily department functioning for maintaining adequate medication supplies for each resident." Attempted interviews on 5/7/18 and 5/8/18 with Client #2 were unsuccessful because Client #2 was on home visit status and guardian did not return Client #2 back to the facility or day program on 5/8/18 by an agreed upon time. Interview on 5/8/18 with Staff #1 revealed: -She was a paraprofessional and worked at the facility since 2/22/16; -She worked third shift (11:00 pm-8:00 am); -Her job responsibilities included administering medications to facility clients in the mornings; -Client #2 was out of his Fluvoxamine Maleate medication at the 7:00 am dosage time on 4/10/18 and 4/11/18; -Client #2's guardian managed Client #2's medication refills with the client's physician and local pharmacy; -The MAR was documented that the facility was out of Client #2's Fluvoxamine Maleate medication supply; -She completed the initial incident report that the aforementioned medication was not administered to Client #2. Interview with the House Manager on 5/8/18 revealed: -Client #2 was out of the facility with his guardian multiple times each month; -Client #2 had been without his Fluvoxamine Maleate because his guardian was not sending Client #2 back to the facility with medication refills;	V 118		

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V 118	Continued From page 4 -Client #2's guardian managed all of Client #2's medical appointments and medication refills; -No known adverse effects with Client #2 having missed 3 doses of the Fluvoxamine Maleate. Interview with the Facility Director on 5/8/18 revealed: -Client #2 was admitted to the facility on 2/20/18; -He was aware of Client #2's missed 3 consecutive medication doses of the Fluvoxamine Maleate in April 2018 because the medication was not at the facility; -Facility staff was not counting and documenting the quantity of Client #2's medications while Client #2 was returning to the facility from home visits; -He stated that Client #2's guardian continued to handle the medication refills and would not switch local pharmacies for the facility to obtain medication refills quicker; -He had spoken with Client #2's guardian about having Client #2's medication available at the facility to administer; -He had not discussed the medication refill issue with Client #2's physician because he did not want to step on the guardian's toes.	V 118		