STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY IPLETED		
		MHL023-160	B. WING		R 05/29		
		WITTE023-100			03/2	.9/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CARING	CARING WAY 114 114 CARING WAY SHELBY, NC 28150						
(X4) ID PREFIX TAG	X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE	
				DEFICIENCY)			
V 000	INITIAL COMMENT	rs	V 000				
	An annual and follo on 5/29/19. Deficie	w up survey was completed ncies were cited.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person and drugs. (2) Medications shat clients only when and client's physician. (3) Medications, included and individual drugs administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Ad all drugs administer current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug. (5) Client requests the corder of a person and th	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be all be prescribe by it trained by a registered nurse, are legally qualified person and and administer medications. Iministration Record (MAR) of a de to each client must be kept administered shall be ally after administration. The and quantity of the drug; and quantity of the drug; administering the drug; and of person administering the for medication changes or					
	checks shall be rec	orded and kept with the MAR appointment or consultation					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		MHL023-160	B. WING		05/2	<29/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CARING	WAY 114	114 CAR	NG WAY NC 28150			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	with a physician.					
	interviews, the facil order of a physiciar current affecting 1 of findings are:	ion, record review and ity failed to follow the written and failed to keep the MAR of 2 clients (Client #1). The				
	-Admission date of Moderate Intellectu Seizure Disorder, Cand Rheumatoid Ar -Physician orderedFlagyl 500mg (and days ordered 3/8/19Lomotil 2.5025m as needed orderedCalcium 600mg (sometime of the source) on the source of the sourc	medications included: tibiotic) every 8 hours for 10 9. ng (antidiarrheal) 4 times daily				
	No other documentCalcium was doct the May MAR from Interview on 5/28/1 -She was house ma -She wrote short te	9 with Staff #1 revealed: anager for his facility. rm and PRN medications on a				
		s opposed to the printed MAR. All MAR sheets were turned month.				

Division of Health Service Regulation

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL023-160	B. WING		F 05/2	R 19/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		-	
		114 CARIN		STATE, ZIF GODE			
	WAY 114	SHELBY,	NC 28150			_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ige 2	V 118				
		the short term medication nedication (Lomotil) but was documentation.					
	Interview on 5/29/19 with Qualified Professional (QP) revealed: -Client #1 took lots of meds and had lots of medical and behavioral issues. Staff stayed on top of medical concernsThe team for Client #1 just had his CNR (Clinical Needs Review) and the agency paperwork for Client #1 was in a folder on his desk. The missing "white MARs" were probably in thatTheir process was to document PRNs and new meds on the white MARs and submit to the office with the printed monthly MARs. The sheets must have gotten separated, but he was sure they were at the office. This deficiency constitutes a recite deficiency and must be corrected within 30 days.						
V 123	10A NCAC 27G .02 REQUIREMENTS (h) Medication error and significant advergenced immediate pharmacist. An entrand the drug reaction	rs. Drug administration errors erse drug reactions shall be	V 123				
	This Rule is not me	et as evidenced by:					

6899

Division of Health Service Regulation STATE FORM

If continuation sheet 3 of 5 L24K11

NAME OF PROVIDER OR SUPPLIER CARING WAY 114 STREET ADDRESS, CITY, STATE, ZIP CODE 114 CARING WAY SHELBY, NC 28150 PREFIX TAG CROSS-REFERENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL, FREGULATION FOR LIBE AND COMPLETE BENEFIC PROPERLY (EACH DEFICIENCY MUST BE PRECEDED BY FULL, FREGULATION FOR LIBE AND COMPLETE BENEFIC PROPERLY FOR LIBE AND COMPLETE BENEFIC FOR LIBERAL FOR LIB	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CARING WAY 114 SUMMARY STATEMENT OF DEFICIENCIES NC 28150			MHL023-160	B. WING			
CARING WAY 114 SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETE TAG PRECEDED TO THE APPROPRIATE COMPLETE DATE	NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVIDERS PLAN OF CORRECTION PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION CAPACH CORRECTION SHOULD BE CAPACH CORPECTION SHOULD BE	CARING	WAY 114		_			
Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist and charted in the client record affecting 1 of 2 current clients (Client #1). The findings are: Record review on 5/28/19 for Client #1 revealed: -Admission date of 4/10/14 with diagnoses of Moderate Intellectual Disability, Bipolar Disorder, Seizure Disorder, Generalized Anxiety Disorder and Rheumatoid Arthritis. Review on 5/28/19 of MARs for March-May 2019 revealed: -Client #1 refused meds on 3/6/19 at 7am, 5pm, 7pm; on 3/7/19 at 7am, 12pm, 2pm, 3pm, 4pm, 5pm and 7pm; and on 3/8/19 at 7am, 12pm, 2pm, 3pm, 4pm, 3pm, 4pm and 5pm. Review on 5/28/19 of incident reports for March-May 2019 revealed: -Level 1 medication error incident reports were completed on 3/7/19 for 7am and 12 pm for Client #1 refusal of medications but the phone call to the pharmacy was not completed until 3/8/19No other documentation of pharmacy or physician contact was made available. Interview on 5/28/19 with Staff #1 revealed: -Client #1 went to the hospital on 3/8/19 but was released back home. "We don't do incident reports (missed meds) when clients go to the hospital""We always do incident reports and call the pharmacy when a client refuses meds."	PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
Interview on 5/29/19 with Qualified Professional (QP) revealed: -Client #1 took lots of meds and had lots of medical and behavioral issues"Staff are usually pretty good about keeping up	V 123	Based on record refailed to ensure me immediately to a physician charted in the client clients (Client #1). The client with clients (Client #1). The client #1 refused in the clients with clients and the clients with clients	view and interview, the facility dication errors were reported sysician or pharmacist and a record affecting 1 of 2 current. The findings are: //28/19 for Client #1 revealed: //28/19 for Client #1 revealed: //10/14 with diagnoses of al Disability, Bipolar Disorder, Generalized Anxiety Disorder thritis. //28/19 for March-May 2019 meds on 3/6/19 at 7am, 5pm, am, 12pm, 2pm, 3pm, 4pm, on 3/8/19 at 7am, 12pm, 2pm, on 3/8/19 at 7am, 12pm for Client ations but the phone call to the completed until 3/8/19. Itation of pharmacy or ras made available. 9 with Staff #1 revealed: //2 with Staff #1 revealed: //2 with Clients go to the dident reports and call the client refuses meds." 9 with Qualified Professional of meds and had lots of foral issues.	V 123			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	A. BUILDING:		·	R		
		MHL023-160	B. WING			9/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CARING	WAY 114	114 CARI				
(V4) ID	SLIMMARY STA		NC 28150	PROVIDER'S PLAN OF CORRECT	ION	(YE)
(X4) ID PREFIX TAG	$_{ m EFIX}$ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CC				(X5) COMPLETE DATE	
V 123	Continued From pa	ge 4	V 123			
V 123	•	ge 4 ports. Don't know what	V 123			

6899

Division of Health Service Regulation STATE FORM