Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING		R
		MHL023-161	B. WING		06/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE	
			ING WAY	,	
CARING WAY 118 SHELB			, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on June 12, 2023. De This facility is licensed	up survey was completed ficiencies were cited. d for the following service 27G .5600C Supervised			
		Developmental Disabilities.			
		d for 4 and currently has a ey sample consisted of ents.			
V 117	27G .0209 (B) Medica	ation Requirements	V 117		
	V 117 27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa				

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

(X6) DATE TITLE

Division of Health Service Regulation

			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL023-161	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
OADINO V	WAY 440	118 CAR	ING WAY		
CARING V	VAY 118	SHELBY	, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
V 117	Continued From page		V 117		
	practitioner.				
	This Rule is not met	as evidenced by:			
	Based on observation	ns, interviews and record			
	reviews the facility fa	ailed to maintain pharmacy			
	packaging labels as r				
		pensed for 1 of 3 audited			
	clients (Client #3). Th	ne findings are:			
	Review on 6/2/23 of 0	Client #3's record revealed:			
	-Date of Admission 8				
		Hypertrophy, Obesity,			
		Intermittent Explosive			
	Disorder, Mild Intelled	ctual Developmental			
	Disability and Paranc	oid Personality Disorder.			
	-Physician's order da	ted 3/29/23 for Lybalvi			
		phan) (antipsychotic) 15			
	, ,	ng- take one tablet by mouth			
	at bedtime.				
	Observation on 6/5/2	3 at 10:11 am of Client #3's			
	medications revealed	l:			
	-A medication bottle I	abeled as Lybalvi 15 mg/ 10			
	mg.				
	The label did not cor	atain:			
	-The client's name				
	-The prescriber's i				
	-The current dispe	ensing date.			
	-Clear directions f	or self- administration.			
		ss, and phone number of			
		•			
		ensing location, and the			
	name of the dispensi	ng practioner.			
	Interview on 6/7/23 w	rith the Qualified			

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 2 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		R
		MHL023-161	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARING V	VAY 118	118 CARIN			
	T	SHELBY, N	28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 117	7 Continued From page 2		V 117		
	Professional #2 (QP) revealed: -The Lybalvi was a sample from the doctorThere should have been a packaging labelFrom now on there will be a label from the doctor or the pharmacy.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications arecorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for acc (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record auticlients.	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The er following:			

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 3 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
						R	
		MHL023-161	B. WING		06	6/12/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE			
		118 CAF	RING WAY				
CARING V	VAY 118	SHELBY	r, NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	÷ 3	V 118				
	facility failed to ensuradministered on the vand failed to keep Maaudited Clients (#1, #failed to ensure 2 of 3 Manager (HM) and S competency in medic findings are: Review on 6/2/23 of 0 - Admission date 5/30	ews and interviews the e medications were vritten order of a physician ARs current for 3 of 3 2 and #3). The facility also 3 audited staff (the House taff #2) demonstrated ation administration. The Client #1's record revealed: 0/14.					
	Reflux Disease, Mild Cholesterol, Lipoma, Type, Mild Intellectua	nsion, Gastroesophageal Renal Insufficiencies, High Schizophrenia Paranoid I Developmental Disability, Psychotic Disorder and					
	dated 9/26/22 revealed - Aripiprazole 15 million by mouth daily (mood - Multivitamin Adults of mouth daily (supplem - Sertraline Hydrochlotone tablet by mouth daily at bedtime (hypodeled) - Benztropine mesyla mouth twice daily (tree - Clomipramine HCL)	grams (mg): take one tablet I stabilizer). 50+: take one tablet by ent). oride (HCL) 100 mg: take daily (mood stabilizer). ng: take one tablet by mouth ertension). te 2 mg: take one tablet by					

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 4 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
		MHL023-161	B. WING	B. WING		
NAME OF B	ROVIDER OR SUPPLIER		DDEEC CITY CTA	TE ZID CODE	06/12/2023	
NAME OF P	ROVIDER OR SUPPLIER	118 CARI	DRESS, CITY, STA	I E, ZIP CODE		
CARING V	VAY 118		NG WAT NC 28150			
040.1=	CHMMADV CT.	<u> </u>		DDOV/DEDIS DI ANI OF CODDECTIO	N ov	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	PLETE
V 118	118 Continued From page 4		V 118			
	disorder). - Trazodone HCL 100 mg: take two tablets by mouth daily at bedtime (antidepressant). - Olanzapine 15 mg: take one tablet by mouth daily at bedtime (antipsychotic). - Lorazepam 1 mg: take one tablet by mouth twice daily (anxiolytic). Review on 6/5/23 of MARs dated April 2023 through June 5, 2023 for Client #1 revealed: - There was no documentation of benztropine mesylate 2 mg being administered from 6/2/23 through 6/5/23.					
	Review on 6/2/23 of Client #2's record revealed: - Date of admission: 7/1/14 Diagnoses: Hypothyroidism, Hyperlipidemia, Essential Primary Hypertension, Autistic Disorder, Moderate Intellectual Developmental Disability, and Morbid Severe Obesity.					
	and Morbid Severe Obesity. Review on 6/5/23 of Client #2's physician's orders dated 9/8/22 revealed: - Haloperidol 5 mg: take one tablet by mouth three times daily and one tablet as needed for agitation (antipsychotic). - Olanzapine 20 mg: take one tablet by mouth daily in the evening (antipsychotic). - Levothyroxine Sodium 88 micrograms (mcg): take one tablet by mouth daily (hypothyroidism). - Vitamin D3 2000 units: take one tablet by mouth daily (supplement). - Verapamil Extended Release (ER) 180 mg: take one tablet by mouth daily with food (hypertension). - Atorvastatin Calcium 40 mg: take one tablet by mouth daily at bedtime (cholesterol). - Farxiga 10 mg: take one tablet by mouth daily in the morning (diabetes). - Loreev Extended Release (XR) 2 mg: take two					

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 5 of 12

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BOILBING.		
		MHL023-161	B. WING		R 06/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
CARING V	NAV 110	118 CARI	NG WAY		
CARING	WAT TIO	SHELBY,	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 118	tablets by mouth daily - Clonidine HCL 0.1 n daily at bedtime (hype - Fluoxetine HCL 40 r daily (mood stabilizer - Topiramate 100 mg: twice daily (hypertens - Lamotrigine HCL 50 mouth twice daily (an: - Metformin HCL 500 with morning meal (bl - Austedo 12 mg: take daily (tremors) Ketoconazole 2% sh weekly with at least th shampooing (antifung Review on 6/5/23 at 1 April 2023 through Ju revealed: - There was no docum Levothyroxine Sodiun	v in the morning (anxiolytic). ng: take one tablet by mouth ertension). ng: take one tablet by mouth in take one tablet by mouth ision). 0 mg: take one tablet by ti-seizure). mg: take one tablet daily ood sugar). e two tablets by mouth twice in the tablets by mouth twice	V 118	BEI MENT)	
	administration for the Review on 6/2/23 of 0 - Date of admission 8 - Diagnoses: Prostation Hypertriglyceridemia, Disorder, Mild Intelled	medication Austedo 12 mg. Client #3's record revealed: /1/10. C Hypertrophy, Obesity, Intermittent Explosive			
	dated 3/29/23 reveale - Trazadone 150 mg: bedtime (antidepress	take one tablet by mouth at ant). take one tablet by mouth at			

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 6 of 12

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		'	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOWIDEN.	A. BUILDING: _	A. BUILDING:		D
		MHL023-161	B. WING		R 06/12/2	2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CARING V	VAV 110	118 CARIN	IG WAY			
CARING	VAT TIO	SHELBY, I	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE 0	(X5) COMPLETE DATE
V 118	V 118 Continued From page 6		V 118			
	mouth daily (supplem - Olanzapine 15 mg: 1 bedtime (antipsychoti - Tamsulosin 0.4 mg: daily (urinary retention - Venlafaxine 150 mg twice daily (antidepre - Fenofibrate 160 mg: daily (cholesterol) Fluticasone propional in each nostril twice daily (anxiolytic - Metformin 500 mg: to daily with dinner (block - Oxybutynin Chloride mouth twice daily (uri - Lybalvi (Olanzapine).	take one tablet by mouth at c). take one capsule by mouth n). : take one capsule by mouth ssant). : take one tablet by mouth ate 50 mcg: Use one spray laily (nasal spray). ike one tablet by mouth ob. icake one tablet by mouth od sugar). is 5 mg: take one tablet by				
	through June 5, 2023 -There was no docum Oxybutynin Chloride 6 6/2/23There were no instru administration for the 10 mg. Interview on 6/5/23 w -Trained in medication - The House Manage clients #1, #2 and #3' place them in a locke for work.					
		administer the medications				

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 7 of 12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL023-161	B. WING		R 06/12/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARING V	VAY 118	118 CARIN				
		SHELBY, N	IC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 7	V 118			
	- When he administered medications, he did not document the MARs.					
	Interview on 6/6/23 w					
	-Trained in medication					
	- Staff #2 had a traum	natic brain injury. comfortable removing				
	medications from the	•				
	administration.					
		Ill the meds (medications)				
		give them in the morning" nister morning medications				
	and would not update	•				
		or work, she would initial				
		nistered on the MARs even				
	though they were give	en by Staff #2. ion to not follow protocol.				
		at we are supposed to do				
		. I take full responsiblity for				
	- Management was n					
	decision to document	the MARs for Staff #2.				
	Interview on 6/5/23 w	ith the Qualified				
	Professional (QP) #2					
	_	aff notices a blank on the				
	MARs they will notify					
		o of any medication hand nd send it to the QP for				
		inistration instructions.				
		se (RN) will begin a new				
		que while training staff to				
		oubble packs" and MARs. Sted to give medications and				
		ave given these medications				
	right after doing so.	•				
	This deficiency consti and must be correcte	itutes a re-cited deficiency d within 30 days.				

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 8 of 12

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R
		MHL023-161	B. WING		06/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CARING V	VAY 118	118 CARII			
		SHELBY,	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 736	Continued From page	8	V 736		
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736		
		EMENTS			
	This Rule is not met as evidenced by: Based on observation and interviews the facility was not maintained in a safe, clean, attractive and orderly manner and was not kept free from offensive odor. The findings are:				
	revealed: -The blind on Client # approximately 10 mis were bent and 18 low -Client #3's bedroom -There was a clear liq base of the toiletThe sink in Client #3' and had standing wat -There was a shoe ra -There were 2 basket	sing louvers. Some louvers vers had pieces missing. had a strong urine odor. uid on the floor around the sbathroom did not drain er. ck with a TV on top of it. ball racks with 16 ack behind the shoe rack edroom window.			
	Interview on 6/7/23 w	ith Client #3 revealed: s out of the way and go out			

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 9 of 12

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			·		R	
		MHL023-161	B. WING		06/1	2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARING V	VAY 118	118 CARIN				
	CLIMMADY CT	SHELBY, N		DROWDEN'S DLANGE CORRECTION		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page	9	V 736			
	-The racks of shoes and basketballs had already been moved out of the way by staff on 6/6/23. Interview on 6/6/23 and 6/7/23 with the House					
	Manager (HM) reveal -Client #3 would some	ed: etimes urinate before				
	making it to the bathroomStaff would clean up after Client #3 immediately if he urinated before making it to the bathroomWould call a plumber to fix the sink in Client #3's bathroomIn the case of an emergency, Client #3 "was					
	under the window and problem."	-				
	-The shoe rack and b moved from in front o window on 6/6/23.	asketball racks had been f Client #3's bedroom				
	Interview on 6/5/23 w Professional (QP) #2 -The blinds in Client #					
	replacedShe would have staff move the shoe rack and basketball racks away from Client #3's window"He (Client #3) takes direction really well, and if he needed to get out of the window, he would move those things (shoe rack and basketball racks) out of the way to get out."					
V 742	27G .0304(a) Privacy		V 742			
	27G .0304(a) Privacy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities.					

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 10 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
						R
		MHL023-161	B. WING		06	6/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CARING V	WAY 118		ING WAY			
		SHELBY	, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 742	Continued From page	e 10	V 742			
		ew, observation and failed to provide privacy r 3 audited clients (Client				
	Record review on 6/5/23 of Client #2's record revealed: -Date of Admission 7/1/14. -Diagnoses: Hypothyroidism, Hyperlipidemia, Essential Primary Hypertension, Autistic Disorder, Moderate Intellectual Developmental Disability and Morbid Severe Obesity. Observation on 6/5/23 at approximately 9:50 am during the facility walk-through revealed: -Client #2's bedroom did not have a doorA gray sheet with baseballs, basketballs, footballs, and numbers on it was hung up in place of the bedroom doorThe sheet was not wide enough to fully cover the doorwayThere were gaps on both sides of the sheet when it was fully extendedClient #2's bedroom window did not have any type of window coveringClient #2's bedroom was on ground level of the facility and there were sister facilities within view.					
	revealed:	on 6/5/23 with Client #2				
	Interview on 6/5/23 w -Did not know the real bedroom door.					
	Interview on 6/5/23 w	rith Staff #3 revealed:				

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 11 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED	
						R
		MHL023-161	B. WING		06	/12/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CARING	WAY 118		ING WAY , NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 742	-Client #2 is Autistic a -Client #2 destroyed -There had not been bedroom for 3 yearsStaff "took the doo eliminate the threat o it" Interview on 6/5/23 w revealed: -"[Client #2's] door years because he do tears the blinds off, th August of last year' Interview on 6/5/23 w Professional (QP) #2 -Client #2 had some at the day program w	and does not like doors. blinds. a door to Client #2's r and blinds away to f him (Client #2) destroying with the House Manager (HM) has been gone for about 2 es not want one. He also hey have been gone since	V 742	DETICIENCY 1		

Division of Health Service Regulation

STATE FORM 9899 YHCU11 If continuation sheet 12 of 12