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 _____	R 10/19/2023

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 10/19/23. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 1 of 3 audited clients (Client #2). The findings are: Review on 7/27/23 of incident report reporting revealed: -8/5/23 Client #2 was out of medication	V 123		

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V 123	Continued From page 1	V 123		

(duloxetine). Contacted House Manager (HM) but no documentation of physician or pharmacist contact.
-8/6/23 Client #2 was out of duloxetine 60mg (milligrams). There was no documentation of call to physician or pharmacist.
-8/7/23 Client #2 was out of duloxetine; HM scheduled appointment for refill today but no documentation contact to physician or pharmacist.
-8/8/23 Client #2 duloxetine not available; pharmacy closed. Will have medication 8/9/23. There was no documentation of call to physician or pharmacist.
-8/20/23 Client #4 was out of medication (omeprazole). There was no documentation of call to physician or pharmacist.

Record review on 10/18/23 for Client #2 revealed:
-Date of admission: 4/24/18
-Diagnoses: Down Syndrome, Mild Intellectual Developmental Disability, Major Depressive Disorder with Psychotic Features, Disruptive Behavior Disorder, Sleep Apnea.
-Physician ordered medications on 11/22/22 included:
-Duloxetine 60mg (depression)- 1 tablet twice daily.

Interview on 10/18/23 with Client #2 revealed:
-He did not remember missing any medication.

Interview on 10/18/23 with the HM revealed:
-She was not the HM but was covering shifts for the facility at the time Client #2 medication was not refilled on time.
-Client #2 needed to see his doctor before getting a refill. It was not just a matter of contacting the pharmacy.
-Client #2 did not seem to have any adverse

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V 123	Continued From page 2 reactions to missing his medication. -Was not aware a physician or pharmacist needed to be contacted immediately for a missed medication. Interview on 10/19/23 with the Qualified Professional (QP) #2 revealed: -QP #1 was relatively new and still learning the processes. -They would need to come up with a better process for missed medication incidents.	V 123		