STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-161	A. BUILDING: _____ B. WING _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING WAY 118	118 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 January 28, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 4 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 interview, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 1 of 4 audited clients (Client #1). The findings are: Review on 1/23/25 of Client #1's record revealed: -date of admission 8/4/23. -diagnoses of Traumatic Brain Injury, Personality	V 123	**V123** **Correct the deficient:** All staff involved in medication management will have re-training on medication handling. A full audit of all medication will be complete biannually to ensure proper administration, labeling, storage, and accurate documentation of medication orders. A new system to verify that the documentation is done when reaching out to the physician or pharmacist when medication errors occur. **Prevent the problem:** Re-training staff implanting a double check method; staff are to check the label on the medication and compare it to the clients MARs before popping the pill from the bubble pack. This ensures the quantity and time frame a medication should be administered. When Residential QP receives the incident report completed for a medication error will ensure that documentation is noted where the physician, or pharmacy was contacted and the instructions received and what drug reactions to be mindful of. **Who will monitor:** Home manger, Residential QP, and Systems Coordinator **How often:** Training of staff will occur annually, and upon hire of new staff. Residential QP/ Home manager will monitor documentation of contact with physician or pharmacist as needed if a medication error occurs. Systems Coordinator will verify documentation when completing quarterly incident report audits.	**2-24-2025**

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V 123	Continued From page 1 Disorder, Obsessive Compulsive Disorder, Diabetes Mellitus Type 2, Hypothyroidism, Ataxia, Encephalopathy, Hypoosmolality, Hyponatremia, Constipation, Adjustment Disorder with Depressed Mood, Epileptic Seizures, Hypertension, Allergic Rhinitis, and Epilepsy. -11/22/24 - physician's order - Trazodone Hydrochloric Acid (Depressed Mood) 150 milligrams - 1 tablet at bedtime. Review on 1/23/25 of facility level 1 incident reports from 11/23/24 through 1/23/25 revealed: -12/26/24 - Client #1 was given 2 Trazodone. "He (Client #1) is only to get one trazadone @ (at) 7pm...two were given...is not sleepy at all up hungry eating and walking around as if he has had no trazodone..." -no indication the pharmacy or physician was contacted. Attempted interview on 1/23/25 with Client #1 revealed he was not interviewable. Interview on 1/22/25 with the House Manager revealed: -responsible to contact pharmacy when there was a medication error and always called poison control as well. -contacted the pharmacy for the above incident but did not document. -also had the staff member re-take the medication training.	V 123		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a	V 131		

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V 131	Continued From page 2 health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the North Carolina Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 3 audited staff (Staff #1). The findings are: Review on 1/23/25 of Staff #1's employee file revealed: -date of hire 2/22/24. -HCPR verification check 2/23/24. Interview on 1/24/25 with Human Resources revealed: -she was responsible to complete the HCPR verifications for new employees. -usually waited until the new employee started their trainings before conducting the HCPR check. -was not aware the HCPR checks needed to be conducted prior to hire and would ensure this was done for future employees.	V 131	**V131** **Correct the deficient:** Retraining of Human Resources explaining the procedural steps required during a health care registry check. Verifying that documentation is recorded correctly and health care registry check is completed prior to hire date. Bi-Annual Audit completed by Human Resources ensuring that any gaps or deficiencies in the verification process are corrected immediately, and staff without verification will not be allowed to continue working until HCPR status is appropriately and correctly documented and verified. **Prevent the problem:** Retraining of Human Resources explaining the procedural steps required during a health care registry check. Develop a reminder system/checklist for HR to ensure that verification is completed prior to hire date. **Who will monitor:** Human Resources **How often:** Upon employment of new staff. Process discussed with HR to use was to in house screen the registry prior to sending info out to have the nationwide background checks completed.	**2-24-2025**
V 742	27G .0304(a) Privacy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and	V 742		

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V 742	Continued From page 3 constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide privacy while dressing for 1 of 4 audited clients (Client #4). The findings are: Review on 1/23/25 of Client #4's record revealed: -date of admission 7/1/14. -diagnoses of Moderate Intellectual Developmental Disability, Autistic Disorder, Hypothyroidism, Hyperlipidemia, Essential Primary Hypertension, Vitamin D Deficiency, Seborrheic Dermatitis and Morbid Severe Obesity. Observation and interview on 1/22/25 at approximately 3:30 p.m. during the facility walk-through with Staff #1 revealed: -Client #4's bedroom did not have a door. -material with baseballs, basketballs, and footballs on it was hung up in place of the bedroom door. -the material was not wide enough to fully cover the doorway. -there were gaps on both sides of the sheet when it was fully extended. -Staff #1 stated Client #4 did not like having a door to his bedroom, he had repeatedly punched holes in it and knocked it down. -having the material up as a door was the only thing he had not torn down thus far. Interview on 1/24/25 with Client #4, while in the presence of his mother, revealed: -he liked to have the sports material up in place of	V 742	**V742** **Correct the deficient:** Conducted a facility assessment to identify deficiencies related to design of cloth door closure, compared to a wooden door. HRC review sent out regarding cloth door closure. Client has requested fabric door closure instead of wooden door closure. A wooden door closure causes aggressive behaviors in client, previously went through numerus wooden doors. Client like the idea of fabric door closure and helped pick design of fabric and helped hang them as well and has remained up. Additional fabric was bought to ensure no gaps when closed to ensure privacy. Adding a third width of fabric will reassure the overage of material is available to be sufficient in meeting the privacy needs associated with the V742 goal criteria. **Prevent the problem:** Staff monitoring of the fabric enclosure to ensure that there are no gaps and that client's privacy is not violated. Checks of fabrics integrity to ensure it does not need replacing. Annual interviews with client on his preference of a door closure, if client's preference remains as a fabric door closure an annual HRC Review will take place. Adding a third width of fabric will reassure the overage of material is available to be sufficient in meeting the privacy needs associated with the V742 goal criteria. **Who will monitor:** Staff will monitor to ensure fabric is closed, and no gaps when client wants privacy. Home manager and Residential QP will do quarterly checks ensure no rips/ damage to fabric to ensure integrity of privacy. Residential QP will ensure during annual plan if client wishes to continue have a fabric closure, or if he would prefer a wooden door; if client continues to want a fabric closure Residential QP will ensure an annual HRC review is performed.	**2-24-2025**

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V 742	Continued From page 4 a bedroom door. -he did not want a door put up to his bedroom, his mother agreed with the client. Interview on 1/27/25 with the Qualified Professional (QP) revealed: -the sheet up as a door had been the only thing he had not torn down. Interview on 1/28/25 with the Systems Coordinator/QP revealed: -Client #4 picked the sports pattern out to hang up for his door. -this was the only thing he had not torn down. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 742	**How often:** Staff monitoring of fabric closure, verifying no gaps and ensuring privacy will be preformed as needed daily when client wants privacy in his room. Home Manager and Residential QP will do quarterly checks of fabric ensuring it's integrity. Residential QP will also do annual interview with client asking preference on door, and if it for him to keep the fabric enclosure and annual HRC review will be performed.	