

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL023-161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2026
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NAME OF PROVIDER OR SUPPLIER CARING WAY 118	STREET ADDRESS, CITY, STATE, ZIP CODE 118 CARING WAY SHELBY, NC 28150
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(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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on March 4, 2026. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 123	<p>27G .0209 (H) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 1 client (Client #3). The findings are:</p> <p>Review on of Client #3's record revealed: -Date of Admission: 4/28/17. -Diagnoses: Schizophrenia Paranoid Type, Mild Intellectual Developmental Disability, Personality</p>	V 123	<p>Incident report forms have been updated to included the pharmacy number that has an after hours service. This will create access to a pharmacy much easier than we had access to in previous years by recently switching to Genoa pharmacy. We did not have access to an after hours service using the previous pharmacy. Trainings in March supervision scheduled for March 10th with staff will cover the correct steps to follow as well as provide question content that staff can refer to when speaking to a pharmacy representative. This will ensure that staff will review if a health risk or behavioral risk is present due to the direct result of the medication error. The incident reports have also been updated to have review area for home managers and OP to verify that the pharmacy was contacted during the medication error event.</p> <p>Reviewing the medication error pharmacy or physician contact requirement has been posted in the homes (3.6.2026), the reporting form was changed to increase the awareness of the correct number to call and elements added to document the response from the on call pharmacy (3.6.2026).</p> <p>Monthly supervision will cover this as well and will be completed by 3-15-2026.</p>	3-15-2026

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Brian Boyle* TITLE: *OP/Systems Admin* (X6) DATE: *3-6-26*

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NAME OF PROVIDER OR SUPPLIER
CARING WAY 118

STREET ADDRESS CITY STATE ZIP CODE
**118 CARING WAY
SHELBY, NC 28150**

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V 123	<p>Continued From page 1</p> <p>Disorder, and Gastroesophageal Reflux Disease.</p> <p>-Physician's orders dated 9/29/25:</p> <ul style="list-style-type: none"> -Clonidine 0.1mg, 1 tab at bedtime. -Trazadone 100mg, 2 tabs at bedtime. -Benzotropine 1mg, 1 tab twice daily. -Olanzapine 15mg, 1 tab at bedtime. -Clomipramine 25mg, 2 caps at bedtime. -Lorazepam 1mg, 1 tab twice daily. <p>Review on 3/2/26 of the facility's incident reports dated 1/26/26 revealed:</p> <ul style="list-style-type: none"> -1/26/26, 7:34pm, Client #3 refused his scheduled nighttime medications (meds). -No documentation of Client #3's missed doses of scheduled nighttime meds having been reported immediately to a physician or pharmacist. <p>Interview on 3/3/26 with Staff #2 revealed:</p> <ul style="list-style-type: none"> -Administered meds. -Would report med errors to the House Manager (HM). -"Management" (HM or Qualified Professional (QP)) would reported immediately to a physician or pharmacist when there was a med error. <p>Interview on 3/4/26 with the HM revealed:</p> <ul style="list-style-type: none"> -Would report immediately to a physician or pharmacist when there was a med error. -Did not report immediately to a physician or pharmacist for Client #3's med error because "he has bad schizophrenia so was just focused on getting him to take his meds." -"Will make sure (for med errors) to contact the pharmacist and that it is documented moving forward." <p>Interview on 3/2/26 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> -"Usually I check the med error reports...Day Program QP reviewing incident reports (during 	V 123		

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V 123	<p>Continued From page 2</p> <p>Client #3's med error) and they didn't know they had to document the pharmacist contact piece." -The HM or herself would contact the pharmacist after being informed there was a med error. -The HM would be responsible for documenting pharmacist contact on the incident form. -No documentation of Client #3's missed doses of scheduled meds on 1/26/26 having been reported immediately to a physician or pharmacist "was just me letting someone else do it and not checking behind to make sure pharmacist was contacted and documented." -"I will figure out a new way to make sure it (med error reported immediately to a physician or pharmacist) is documented. I will take it back over (reviewing med error reports)."</p>	V 123		