PRINTED: 08/07/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-up survey on July 23, 2019 and July 24, 2019.	D 000	Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with the State Laws.	
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety In Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food was free from contamination related to unlabeled and undated refrigerated items. The findings are: Observations of the refrigerator on 07/23/19 at 9:15am revealed: -Ten cooked French toast sticks on a Styrofoam plate covered with plastic with no label or date. -Six ham slices covered with plastic with no label or date. -One-half of a ham loaf covered with plastic with no label or date. -Tuna salad on a Styrofoam plate covered with another Styrofoam plate with a label but no date. -Twelve sausage links on a Styrofoam plate covered with plastic with no label or date. -Fourteen sausage patties on a Styrofoam plate covered with plastic with no label or date. -Eight pancakes on a Styrofoam plate covered with plastic with no label or date.	D 282	All Dietary staff provided with in-service on food safety and importance of labeling and dating all opened food sources. Per end of each shift, dietary staff will monitor food sources to assure dates and labels are maintained for that shift. If food sources were failed to be labeled or dated, any food items of concern will be discarded. ED to complete random kitchen audits to assure food sources are dated and labeled correctly. Any discovered concerns will result in an immediate write up/corrective action for staff member failing to complete required documentation.	8/30/19 8/30/19 8/30/19 8/30/19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 8/27/19

STATE FORM 6899 3U9L11 If continuation sheet 1 of 15

Reviewed and acknowledged on 09/05/2019 RH

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D 282	Continued From page 1 -Ground sausage in a sealed plastic bag with no label or date. -Six biscuits in a paper bowl covered with plastic with no label or date. -Six garlic rolls in a paper bowl covered with plastic with no label or date. -The Dietary Manager removed each of these items and disposed of them in the trash. Observation of the exterior of the refrigerator on 07/23/19 at 9:15am was a sign that read "Please make sure you label and date anything you put in the fridge." Interview with the DM on 07/24/19 at 10:20am revealed: -Staff were aware they were supposed to label and date left-overs. -The dietary staff were given training and a food service orientation manual that indicated the following "All leftovers should be labeled with the date the item was placed in the refrigerator. This ensures everyone knows how long the leftovers have been in storage." -Most of the unlabeled, undated food was served on 07/20/19 and 07/21/19. -Only two dietary staff worked 07/20/19 and 07/21/19 and both had received and taken a post-test on information in the food service orientation manual in May 2019. -She was responsible for making sure food items were labeled and dated. -In her absence, the cook was responsible for making sure food items were labeled and dated. Interview with the cook on 07/24/19 at 11:52am revealed: -She worked on 07/20/19 and 07/21/19. -She knew she was supposed to label and date anything that went into the refrigerator.	D 282		

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D 282	Continued From page 2 -The only items she put in the refrigerator over the weekend were pot roast and sausage links and she put a label with the date on both items. -Staff moved the food around in the refrigerator and may have knocked off the labels. -It was all of the kitchen staff's responsibility to make sure food items were labeled and dated in the refrigerator. Interview with the Administrator on 07/24/19 at 11:04am revealed: -She was not aware there was cooked food not being labeled or dated in the refrigerator. -Her expectations are for the DM to make sure food was labeled and dated. -In the absence of the DM the cook was responsible to make sure food was labeled and dated. Attempted telephone interviews on 07/24/19 at 11:00am and 2:25pm with the dietary aide who worked on 07/20/19 and 07/21/19 were unsuccessful.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 3 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents related to administering medications used to treat depression (#3) and blood pressure (#4) following a discontinuation order. The findings are: 1. Review of Resident #3's current FL2 dated 12/31/18 revealed: -Diagnoses included anxiety, depression, asthma, and low back pain. -There was a physician's order for Rexulti 3mg take 1 tablet every morning (used to treat depression). Review of Resident #3's signed physician's order dated 05/31/19 revealed a physician's order to decrease Rexulti to 2mg take 1 tablet daily. Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Rexulti 3mg take 1 tablet daily scheduled to be administered daily at 9:00pm. -Rexulti 3mg was documented as administered daily from 06/01/19 to 06/02/19, 6/16/19 to 6/26/19, and 6/30/19. -There was a computer-generated entry for Rexulti 2mg take 1 tablet daily scheduled to be	D 358	Complete POS/vs E-Mar audit conducted to assure medications being administered are correct and up to date with current physician's orders. Weekly med cart audits to occur to ensure medications are available for administration per MD orders. RCC to conduct random medication pass observation to ensure medications are administered as prescribed. All Medication aides to receive training on medication administration and the importance of appropriate documentation.	8/30/19 8/30/19 8/30/19 8/30/19

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D 358	Continued From page 4 administered daily at 9:00pm. -Rexulti 2mg was documented as administered daily from 06/03/19 to 06/10/19 at 9:00pm and 06/17/19 to 06/27/19 at 9:00am. -Resident #3 was out of the facility on leave from 6/12/19 to 6/16/19 and 06/28/19 through the morning of 06/30/19. Review of Resident #3's July 2019 eMAR revealed: -There was a computer-generated entry for Rexulti 3mg take 1 tablet daily scheduled to be administered daily at 9:00pm. -Rexulti 3mg was documented as administered from 07/01/19 to 07/08/19 and 07/12/19 to 07/22/19 at 9:00pm. -There was a computer-generated entry for Rexulti 2mg take 1 tablet daily scheduled to be administered daily at 9:00pm. -Rexulti 2mg was documented as administered from 07/01/19 to 07/08/19 and 07/12/19 to 07/22/19 at 9:00am. -Resident #3 was out of the facility on leave from 07/10/19 through the morning of 07/12/19. Observation of Resident #3's medication on hand on 07/23/19 at 2:35pm revealed: -Rexulti 3mg was not available to be administered to Resident #3. -A multi-dose package of medications dispensed on 07/18/19 that contained a 7-day supply of Rexulti 2mg was available to administer to Resident #3 beginning 07/24/19.	D 358		
	Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/19 at 9:56am revealed: -The pharmacy did not have a discontinuation order for Rexulti 3mg. -The pharmacy had last filled a 30-day supply of			

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D 358	Continued From page 5 Rexulti 3mg take 1 tablet daily from a refill request faxed from the facility on 06/11/19. -The Rexulti 3mg was delivered to the pharmacy in an individual medication card containing only the Rexulti 3mg. -A 30-day supply of Rexulti 2mg was last filled on 06/12/19 and was dispensed in the multi-dose packaging system. Interview with a medication aide (MA) on 07/23/19 at 2:25pm revealed: -She did not know Resident #3 had received Rexulti 3mg after the medication had been discontinued and decreased to Rexulti 2mg. -She did not know Resident #3 had received both the Rexulti 2mg and 3mg on multiple days in June and July. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:10am and 2:24pm revealed: -She did not remember a medication order decreasing Resident #3's dose of Rexulti from 3mg to 2mg. -She had "missed" the medication order changing the dose of Rexulti for Resident #3. -She did not review the eMARs from month to month or compare the eMARs to new medication orders. -She, the Assistant RCC, and the Administrator was working on developing an audit procedure. -She did not remove the Rexulti 3mg from the medication cart. -She did not remember removing the Rexulti 3mg order from the eMAR. Interview with the Administrator on 07/24/19 at 2:24pm revealed: -She did not know Resident #3's Rexulti 3mg was discontinued as ordered by a physician.	D 358		

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D 358	Continued From page 6 -She did not know Resident #3's Rexulti 3mg was not removed from the eMAR. -She did not know Resident #3 had received both Rexulti 2mg and 3mg during June and July. Attempted telephone interview with Resident #3's psychiatrist on 07/24/19 at 9:40am was unsuccessful. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/19 at 9:56am. Refer to the interview with a medication aide (MA) on 07/23/19 at 2:25pm. Refer to the interview with the Administrator on 07/24/19 at 2:24pm. 2. Review of Resident #4's current FL2 dated 07/11/19 revealed diagnoses included diabetes, lactic acidosis, hypertension, and acute kidney injury. a. Review of Resident #4's physician's orders dated 05/02/19 revealed a physician's order for hydrochlorothiazide 25mg take 1 tablet daily (used to treat swelling and high blood pressure). Review of Resident #4's clarification order following a hospital discharge dated 07/11/19 revealed a physician's order to discontinue hydrochlorothiazide. Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for hydrochlorothiazide 25mg take 1 tablet daily scheduled to be administered at 9:00am.	D 358		

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D 358	Continued From page 7 -Hydrochlorothiazide was documented as administered from 07/01/19 to 07/08/19, 07/12/19, and 07/19/19 to 07/23/19 at 9:00am. -Resident #4 was out of the facility in the hospital from 07/09/19 to 07/11/19. Observation of Resident #4's medication on hand 07/24/19 at 11:30am revealed: -There was an individual medication card containing 4 tablets of hydrochlorothiazide last filled 07/03/19 available to administer to Resident #4. -A 7-day supply of hydrochlorothiazide was dispensed on 07/18/19 was available to be administered to Resident #4 in the current multi-dose package started 07/24/19. -A note was written on the inside cover of the multi-dose package that hydrochlorothiazide was discontinued. Telephone interview with a pharmacy representative from the facility's contracted pharmacy on 07/24/19 at 2:00pm revealed: -The pharmacy did not have a physician's order to discontinue hydrochlorothiazide. -The original physician's order for hydrochlorothiazide was dated 05/02/19. -A 6-day supply of hydrochlorothiazide was dispensed on 07/03/19 to cycle the medication. -Hydrochlorothiazide was dispensed as a cycled medication in the multi-dose package on 07/17/19, 07/24/19, and was scheduled to be dispensed on 07/31/19.	D 358		
	Interview with the medication aide (MA) on 07/24/19 at 2:10pm revealed: -She did not know the hydrochlorothiazide for Resident #4 was discontinued. -She did not look at the inside cover of the multi-dose mediation package unless she had to			

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D 358	Continued From page 8 identify a medication in the mediation card. Interview with the Assistant Resident Care Coordinator on 07/24/19 at 2:24pm revealed: -She knew Resident #4's hydrochlorothiazide was discontinued. -She remembered discontinuing the medication order on the eMAR. -The medication order for hydrochlorothiazide had "repopulated on the eMAR." -She did not know why the order was not removed from the eMAR. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 2:24pm revealed: -She did not know Resident #4 had a physician's order to discontinue the hydrochlorothiazide. -She did not remember processing the order to discontinue the hydrochlorothiazide from the eMAR or remove the medication from the medication cart. Interview with the Administrator on 07/24/19 at 2:24pm revealed she did not know Resident #4 was administered hydrochlorothiazide after the physician had written an order to discontinue the medication. Attempted telephone interview with Resident #3's primary care physician on 07/24/19 at 1:56pm was unsuccessful. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/19 at 9:56am. Refer to the interview with a medication aide (MA) on 07/23/19 at 2:25pm. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 9 07/24/19 at 2:24pm. b. Review of Resident #4's current FL2 dated 07/11/19 following a hospital discharge revealed a physician's order for labetalol 300mg take 1 tablet three times daily; hold if pulse <60. Review of Resident #4's physician's order dated 05/02/19 revealed a physician's order for labetalol 300mg take 1 tablet three times daily. Review of Resident #4's physician's order dated 06/27/19 revealed a physician's order to increase labetalol to 400mg take 1 tablet three times daily. Review of Resident #4's June 2019 electronic Medication Administration Record revealed: -There was a computer-generated entry for labetalol 200mg take 2 tablets (400mg) three times daily scheduled to be administered at 8:00am, 2:00pm and 8:00pm. -Labetalol 200mg take 2 tablet three times daily was documented as administered at 8:00am, 2:00pm and 8:00pm on 06/29/19 and 06/30/19. -There was a computer-generated entry for labetalol 300mg take 1 tablet three times daily; hold if pulse <60. scheduled to be administered at 8:00am, 2:00pm and 8:00pm. -Labetalol 300mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 06/01/19 to 06/30/19 except for 4 times when Resident #4's pulse was <60. Review of Resident #4's July 2019 eMAR revealed: -There was a computer-generated entry for labetalol 200mg take 2 tablets (400mg) three times daily scheduled to be administered at 8:00am, 2:00pm and 8:00pm. -Labetalol 200mg was documented as	D 358		

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D 358	Continued From page 10 administered at 8:00am, 2:00pm and 8:00pm on 07/01/19 to 07/02/19, 07/04/19 and 07/05/19 at 8:00am, 07/13/19 to 07/15/19, and 07/18/19 at 8:00pm to 07/23/19. -There was a computer-generated entry for labetalol 300mg take 1 tablet three times daily; hold if pulse <60 scheduled to be administered at 8:00am, 2:00pm and 8:00pm. -Labetalol 300mg was documented as administered three times daily at 8:00am, 2:00pm and 8:00pm on 07/01/19 to 07/08/19, 07/12/19/19-07/23/19. -Resident was out of the facility in the hospital from 07/09/19 to 07/23/19. Observation of Resident #4's medication on hand 07/24/19 at 11:30am revealed: -A 7-day supply of labetalol 200mg and 300mg was dispensed on 07/18/19 and was available to be administered to Resident #4 in the multi-dose package cards that was started on 07/24/19. -Both strengths of labetalol were in a bubble labeled for morning and evening administration. -An individual medication card containing 12 tablets of labetalol 300mg dispensed on 07/17/19 was available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/19 at 9:56am revealed: -The pharmacy did not have a discontinuation order for labetalol 200mg take 2 tablets three times daily. -The pharmacy had to have a physician's order stating a medication was discontinued before removing medication from eMAR. -The pharmacy dispensed 66 tablets of Labetalol 200mg take 2 tablet three times daily on 06/28/19 and 60 tablets on 07/13/19. -The pharmacy dispensed 18 tablets of Labetalol	D 358		

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D 358	Continued From page 11 300mg take 1 tablet three times daily on 07/17/19. -Labetalol 200mg and 300mg were flagged to dispense in the multi-dose packaging. Interview with a medication aide (MA) on 07/24/19 at 2:10pm revealed: -She knew Resident #4 was not supposed to be taking labetalol 200mg take 2 tablet three times daily. -She discovered the error the previous week and had notified the Resident Care Coordinator (RCC). -She had called the pharmacy and refilled the labetalol 300mg to make sure the correct medication was available to be administered to Resident #4. -She removed the labetalol 200mg tablets from the multi-dose package and wasted the tablets when she administered Resident #4's morning medications on 07/24/19. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 2:24pm revealed: -She did not know Resident #4 was receiving two different strengths of labetalol. -She did not remember seeing the order to change Resident #4's labetalol dose. -She did not remove the labetalol 200mg from the cart when the medication was discontinued. Interview with the Administrator on 07/24/19 at 2:24pm revealed she did not know Resident #4 was receiving both labetalol 200mg and labetalol 300mg on multiple days during June and July. Attempted telephone interview with Resident #3's primary care physician on 07/24/19 at 1:56pm was unsuccessful.	D 358		

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D 358	Continued From page 14 the physician's order sheet weekly to make sure the eMARs were correct based on the physician's orders. -She did not have a current procedure to audit the eMARs to each individual new medication order. -She assumed the physician's order sheet was a correct listing of all the medication orders for a resident. Interview with the Administrator on 07/24/19 at 2:24pm revealed: -The RCC was responsible for faxing new medication orders or discontinuation orders to the pharmacy. -The pharmacy entered the order on the eMAR. -The RCC was responsible for approving medication orders from the pharmacy before the orders appeared on the eMAR. -The RCC was responsible for removing discontinued medications from the medication cart.	D 358		

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CLEVELAND HOUSE	950 HARDIN DRIVE 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
D 358	Continued From page 12 Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/19 at 9:56am. Refer to the interview with a medication aide (MA) on 07/23/19 at 2:25pm. Refer to the interview with the Administrator on 07/24/19 at 2:24pm. --- Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/19 at 9:56am revealed: -The facility had recently switched to a multi-dose medication packing system where all morning medications were packaged in a single bubble on a medication card and all evening medications were packaged together. -The facility was responsible for faxing all medication orders to the pharmacy to be processed, including discontinuation orders. -The pharmacy was responsible for entering the medication orders in the eMAR software. -The facility was responsible for approving the medication orders before it appeared on the eMAR. -The facility was responsible for approving discontinued medication orders to remove the order from the eMAR. -The pharmacy software did not alert the pharmacist during data entry of a duplicate medication unless the new medication order was for the same medication and strength. Interview with a medication aide (MA) on 07/23/19 at 2:25pm revealed: -The RCC was responsible for faxing medication orders to the pharmacy and approving orders on the eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

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D 358	Continued From page 13 -The MAs were responsible for communicating information related to medication changes by "word of mouth" to the next shift. -The facility had recently switched to a multi-dose packaging for medications. -The medications were delivered weekly and a new pack of medications was started every Wednesday. -The third shift MA was responsible for making sure the medication packages contained the correct medications before putting the new packages on the medication cart. -She would scan the multi-dose pack of medications prior to administration and the computer alerted her if a medication was in the multi-dose pack but not on the eMAR. -If she received an alert that an incorrect medication was in the multi-dose pack then she would alert the RCC. -She was not aware of the facility having a policy or procedure for making sure discontinued medications were removed from the medication cart. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:10am revealed: -She was responsible for faxing all medication orders to the pharmacy to be processed. -She was responsible for approving medication orders to appear on the eMAR. -She was responsible for making sure discontinued medications were removed from the medication carts. -The facility did not have a policy related to pulling discontinued medications from the medication carts. -The facility did not have a set procedure for auditing the medication carts but was working to develop a procedure. -She had recently started comparing the eMAR to	D 358		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL023045 Y1	A. Building B. Wing Y2	7/24/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0364 Reg. # 10A NCAC 13F .1004(g) LSC	Correction Completed 07/24/2019	ID Prefix D912 Reg. # G.S. 131D-21(2) LSC	Correction Completed 07/24/2019	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Renee Howard, PharmD	07/25/2019
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/11/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

Post Annual/ Re- Visit Survey Plan

Community: Cleveland House **Date: 8/27/19**

Deficiency Free ☐ **Standard Deficiency ☒_____**

A-1 ☐ _____ A-2 ☐ _____ B ☒ _____

IPL ☐ PL ☐ SOA ☐

Plan to Correct

Citation D282 Nutrition and Food

1. All Dietary staff provided with in-service on food safety and importance of labeling and dating all opened food sources.
2. Per end of each shift dietary staff will monitor food sources to assure dates and labels are maintained for that shift. If food sources were failed to be labeled or dated, any food items of concern will be discarded.
3. ED to complete random kitchen audits to assure food sources are dated and labeled correctly.
4. Any discovered concerns will result in an immediate write up/corrective action for staff member failing to complete required documentation.

Citation D 358 Med Admin

1. Complete POS/vs E-Mar audit conducted to assure medications being administered are correct and up to date with current physician's orders.
2. Weekly med cart audits to occur to ensure medications are available for administration per MD orders
3. RCC to conduct random medication pass observation to ensure medications are administered as prescribed.
4. All Medication aides to receive training on medication administration and the importance of appropriate documentation.

Resources/ Support

	LHPS NURSE- DEBBIE DYE **DIETARY MANAGER-SHERRY THOMPSON**

Managers to assist in compliance

Name	Title	Assignment
Heather Strickland	Executive Director	Random Audits
Amberly Colston	Resident Care Director	Random Cart Audits & training
Sherry Thompson	Dietary Manager	In-service/ Monitor

Specific training required to correct the citation/ deficiency

Instructor assigned	Topic
Sherry Thompson	Rule-0904 Food Procedure & safety Dating/Labeling of left overs Review of Food Safety (Food Manual)
Debbie Dye	Medication Administration Documentation

Citations

Rule Area	Type of Violation

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 12, 2019

Mel Deaton, Executive Assistant
Shelby House, LLC, Licensee
Cleveland House
PO Box 2568
Hickory, NC 28603

mdeaton@affinitylivinggroup.com

Re: Annual and Follow-up Survey completed on July 24, 2019 (ASPEN Event ID 8U9L11)

Facility: **Cleveland House**
Licensure Number: **HAL-023-045**
County: **Cleveland**

Dear Mr. Deaton:

Thank you for the cooperation and courtesy extended during the survey completed July 24, 2019 by staff with the Adult Care Licensure Secton.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A

response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **September 2, 2019**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **September 2, 2019**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at (828) 526-6611. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Renee Howard, PharmD

Renee Howard, PharmD, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Tom Ensley, Supervisor/Designee, Cleveland County DSS
Nina Warwick-Joyner, Administrator w/enclosures
Heather Bingham, Team Supervisor, West 2 Region, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: **http://www2.ncdhhs.gov/dhsr/customerservice.html**
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)