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 _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	Initial Comments The Adult Care Licensure Section completed an annual and follow up survey from 11/15/22 through 11/16/22.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure contact with a resident's physician for clarification of a treatment order for 1 of 5 sampled residents (#4) who had an order for a cognitive-enhancing medication (#4). 2. Review of Resident #4's current FL-2 dated 06/10/22 revealed: -Diagnoses included Alzheimer's dementia, muscle cramps and hyperlipidemia. -There was an order for donepezil 10mg (used to treat Alzheimer's dementia) take one tablet at bedtime.	D 344		

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D 344	Continued From page 1	D 344		

Review of Resident #4's progress note dated 10/21/22 written by the former Resident Care Coordinator (RCC) revealed that donepezil 10mg was discontinued by Resident #4's primary care provider (PCP).

Review of Resident #4's signed Physician's Order sheet dated 11/07/22 revealed there was an order for donepezil 10mg take one tablet at bedtime.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for donepezil take one tablet at bedtime scheduled at 9:00pm which was discontinued on 10/25/22.
-There was a second entry for donepezil take one tablet at bedtime scheduled at 8:00pm which was documented as administered from 10/29/22-10/31/22.

Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for donepezil 10mg take one tablet at bedtime scheduled for 8:00pm that was discontinued on 11/02/22.
-There was documentation donepezil 10mg was administered on 11/01/22.
-There were no other entries for donepezil 10mg.

Observation of the medications on hand for Resident #4 on 11/16/22 at 2:20pm revealed there were 7 of 7 donepezil 10mg tablets remaining that were sent out for delivery on 11/14/2022 with a start date of 11/16/22.

Telephone interview with a representative from the facility's contracted pharmacy on 11/16/22 at 12:05pm revealed:

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D 344	Continued From page 2 -There was an order on file for donepezil 10mg take one tablet at bedtime for Resident #4. -Donepezil 10mg had been an active order and dispensed weekly with the cycle fill of medications for Resident #4 since the pharmacy started serving the facility in July 2022. -There was a medication bubble pack labeled donepezil 10mg take one tablet at bedtime that was dispensed on 11/14/22 for a quantity of 7 tablets with a start date of 11/16/22. -Donepezil 10mg was dispensed on 11/07/22 with a start date of 11/09/22 for a quantity of 7 tablets. Interview with a medication aide (MA) on 11/16/22 at 2:00pm revealed: -She was not aware that donepezil 10mg was dispensed in Resident #4's medication bubble packs and being administered to Resident #4, but was not being documented on the eMAR. -MAs were responsible to ensure that medications were documented on the eMAR when they were administered and that medications orders matched on the eMAR and the medication bubble packs. -Her normal process for a new medication order was to write down what the doctor told her in a verbal order and fax the written verbal order to the provider so that they could sign the order. -MAs faxed orders to the pharmacy and the pharmacy put new medication order entries on the eMAR. Interview with a MA/Supervisor on 11/16/22 at 2:15pm revealed: -She was not aware that the order for donepezil 10mg was not clarified as to whether it should be continued or discontinued. -Resident #4's Primary Care Provider (PCP) had changed recently around the time that the donepezil was discontinued.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 3	D 344		

-Her normal process for a new medication order was to write down what the doctor told her in a verbal order and fax the written verbal order to the pharmacy.
-The pharmacy put new medication order entries on the eMAR since the facility changed pharmacies in July 2022.
-If she noticed that a medication order did not match on the medication bubble packs and the eMAR, she let the RCC know.
-MAs were responsible to administer medications as ordered by the provider.
-MAs and the RCC were responsible to make sure that medications that were administered were documented on the eMAR.

Interview with the Executive Director (ED) on 11/16/22 at 2:55pm revealed:
-She was not aware that Resident #4's medication order for donepezil was not clarified.
-Resident #4's PCP had changed at the end of October 2022 or the beginning of November 2022.
-MAs were responsible to administer medications as ordered.
-MAs and Supervisors were responsible to document their own medication administrations.
-The pharmacy changed medication order entries on the eMAR.
-She expected MAs or Supervisors to cross out a medication order on the medication bubble packs if an order was discontinued and the discontinued medication was still included in the weekly bubble pack.
-Donepezil was not crossed out on Resident #4's medication bubble pack.
-The facility did not currently have a RCC for a period of about one week.
-The RCC normally audited the medications carts and the eMARS weekly when the weekly cycle fill

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D 344	Continued From page 4 of medications was delivered to the facility from the pharmacy. -She expected the RCC to follow up with the pharmacy to ensure that discontinued medications were removed from the medication bubble backs and not being sent with the weekly cycle fill. -She was responsible for the RCC's normal duties until she was able to hire a new RCC. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care provider (PCP) on 11/16/22 at 3:40pm was unsuccessful.	D 344		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering	D 367		

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D 367	Continued From page 5	D 367		

the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (#5) related to the documentation of an iron supplement.

The findings are:

1. Review of Resident #5's current FL-2 dated 06/13/22 revealed:
-Diagnoses included altered mental status, hypotension and legal blindness.
-There was no order for ferrous gluconate 324mg (used to treat or prevent iron deficiency) listed on the current FL-2.

Review of Resident #5's previous physician's order dated 04/23/22 revealed an order for ferrous gluconate 324mg take one tablet daily.

Review of Resident #5's September, October, and November 2022 electronic Medication Administration Record (eMARs) revealed there was no entry for ferrous gluconate 324mg take one tablet daily on the eMARs.

Observation of the medications on hand for Resident #5 on 11/16/22 at 11:53am revealed there were 6 of 7 ferrous gluconate tablets remaining that were dispensed on 11/14/2022 with a start date of 11/16/22.

Telephone interview with a representative from

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D 367	Continued From page 6 the facility's contracted pharmacy on 11/16/22 at 12:05pm revealed: -The pharmacy had served the facility since July 2022. -There was an order on file for ferrous gluconate 324mg take one tablet daily for Resident #5. -The initial order for ferrous gluconate 324mg take one tablet daily for Resident #5 was written on 04/23/22. -Ferrous gluconate 324mg had been an active order and dispensed weekly with the cycle fill of medications for Resident #5 since the pharmacy started serving the facility in July 2022. -There was a medication bubble pack labeled ferrous gluconate 324mg take one tablet daily that was dispensed on 11/14/22 with a start date of 11/16/22 with 6 of 7 tablets that remained. -Ferrous gluconate 324mg was dispensed on 11/07/22 with a start date of 11/09/22 for a quantity of 7 tablets. Interview with a medication aide (MA) on 11/16/22 at 2:00pm revealed: -She was not aware ferrous gluconate was not being documented on the eMAR when it was administered to Resident #5 -There was no entry for ferrous gluconate on the eMAR. -Resident #5 was administered ferrous gluconate daily for the past few months. -MAs were responsible to ensure that medications were documented on the eMAR when they were administered and that medication orders matched on the eMAR and the medication bubble packs. -Her normal process for administering medications was to take the medication out of the bubble pack, put the medication in a medication cup, administer the medication to the resident and then document administration on the eMAR.	D 367		

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D 367	Continued From page 7 -Her normal process for a new medication order was to write down what the doctor told her in a verbal order and fax the written verbal order to the provider so that they could sign the order. -MAs faxed orders to the pharmacy and the pharmacy put new medication order entries on the eMAR. -The Resident Care Coordinator (RCC) or Executive Director (ED) verified the order entries that were placed on the eMARs by the pharmacy. Interview with a MA/Supervisor on 11/16/22 at 2:15pm revealed: -She was not aware ferrous gluconate was in Resident #5's medication bubble packs and being administered to Resident #5 but was not being documented on the eMAR. -There was no entry for ferrous gluconate on the eMAR. -Her normal process for a new medication order was to write down what the doctor told her in a verbal order and fax the written verbal order to the pharmacy. -The pharmacy put new medication order entries on the eMAR since the facility changed pharmacies in July 2022. -If she noticed that a medication order did match on the medication bubble packs and the eMAR, she let the RCC know. -MAs were responsible to administer medications as ordered by the provider. -MAs and the RCC were responsible to make sure that medications that were administered were documented on the eMAR. -The RCC did weekly medication cart audits. -She sometimes helped the RCC with the medication cart audits, and when she did, she also looked at the eMAR to ensure that orders matched.	D 367		

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D 367	Continued From page 8 Interview with the Executive Director (ED) on 11/16/22 at 2:55pm revealed: -She was not aware that Resident #5's medication order for ferrous gluconate was not entered on the eMAR and not being documented as administered on the eMAR. -MAs were responsible to administer medications as ordered. -She expected staff who administered medications to check the eMAR and compare medication orders on the eMAR for orders on the medication bubble pack. -MAs and Supervisors were responsible to document their own medication administrations. -The pharmacy changed medication order entries on the eMAR. -The RCC was normally responsible for medication cart audits and comparing orders on the eMAR to orders labeled on the medication bubble packs from the pharmacy. -The RCC normally audited the medications carts and the eMARS weekly when the weekly cycle fill of medications was delivered to the facility from the pharmacy. -She expected MAs or Supervisors to cross out a medication order on the medication bubble packs if an order was discontinued and the discontinued medication was still included in the weekly bubble pack. -The facility did not currently have a RCC for a period of about one week. -She expected the RCC to follow up with the pharmacy to ensure that discontinued medications were removed from the medication bubble backs and not being sent with the weekly cycle fill. -She was responsible for the RCC's normal duties until she was able to hire a new RCC. Based on observations, interviews, and record	D 367		

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D 367	Continued From page 9 reviews, it was determined Resident #5 was not interviewable. Attempted interview with Resident #5's primary care provider (PCP) on 11/16/22 at 3:40pm was unsuccessful.	D 367		