

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL023045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/10/2026
NAME OF PROVIDER OR SUPPLIER CLEVELAND HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 conducted a follow up survey on 09/09/26 - 09/10/26.	{D 000}			
D 344	<p>10A NCAC 13F .1002(a) Medication Orders</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure physician orders were clarified for 1 of 5 sampled residents who had orders for a laxative used to prevent hepatic encephalopathy (#2).</p> <p>The findings are:</p> <p>1. Review of Resident #2's FL2 dated 03/13/26 revealed diagnoses included cirrhosis non-alcoholic (permanent liver scarring), NASH (severe, irreversible scarring and hardening of the liver), paroxysmal atrial fibrillation (irregular and</p>	D 344			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 344	<p>Continued From page 1</p> <p>fast heart rhythm), thrombocytopenia (low blood platelet count), hypertension, polyps.</p> <p>Review of Resident #2's hospital discharge orders dated 09/08/26 revealed:</p> <ul style="list-style-type: none"> -She was discharged from the hospital on 09/08/26. -There was an order for 45ml of lactulose three times per day at 8:00am, 2:00pm and 8:00pm. <p>Review of Resident #2's 09/08/26 - 09/09/26 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for lactulose 45ml scheduled at 8:00pm. -There was documentation lactulose was not administered on 09/08/26 at 8:00pm with the reason indicated as "other" with no explanation. -There was documentation lactulose was not administered on 09/09/26 at 8:00am with the reason indicated with a "dash" with no explanation. -There was an entry on 09/09/26 at 2:00pm and 8:00pm indicating lactulose was discontinued. <p>Interview with Resident #2 on 09/09/26 at 9:20am revealed:</p> <ul style="list-style-type: none"> -She kept having to go to the hospital because she was not administered her lactulose consistently by staff. -She was discharged on 09/08/26 from the hospital and returned to the facility. -When she did not get the lactulose as scheduled, it caused her ammonia levels in her body to be too high and she became confused, could not process thoughts, and could not talk. <p>Observation in Resident #2's room on 09/09/26 at 9:28am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) entered Resident #2's 	D 344			

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D 344	<p>Continued From page 2</p> <p>room and handed Resident #2 a medication cup containing pills.</p> <p>-Resident #2 asked the MA where her lactulose was and the MA responded that the lactulose was discontinued.</p> <p>-Resident #2 asked why the lactulose was discontinued.</p> <p>-The MA told Resident #2 she did not know.</p> <p>-Resident #2 told the MA she would call her provider because she had to have the medication.</p> <p>-The MA told Resident #2 she would let the Resident Care Coordinator (RCC) know so the RCC could check on it.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 09/10/26 at 9:01am and 11:09am revealed:</p> <p>-There was an order dated 05/22/26 for lactulose.</p> <p>-The lactulose was picked up by the facility on 08/05/26.</p> <p>-The pharmacy did not discontinue lactulose on Resident #2's eMAR.</p> <p>Telephone interview with Resident #2's Primary Care Provider (PCP) on 09/10/26 at 10:43am.</p> <p>-Resident #2 was ordered lactulose to increase bowel movements.</p> <p>-Resident #2 reported during the last visit that she was not receiving medication on time.</p> <p>-Resident #2 had an increase chance of hepatic encephalopathy if doses were missed.</p> <p>-Missed doses will also increase chance of hospitalization, lethargy, unresponsiveness or death.</p> <p>Interview with the MA on 09/09/26 at 3:10pm revealed:</p> <p>-She worked first shift and had worked with Resident #2.</p>	D 344		

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D 344	<p>Continued From page 3</p> <ul style="list-style-type: none"> -She had not administered lactulose to Resident #2 because it was discontinued. -The RCC was responsible for updating Resident #2's eMAR. <p>Interview with the RCC on 09/09/26 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's order should have been clarified when lactose was discontinued on the eMAR. -She was responsible for approving orders and eMARS in the facilities system. -She missed Resident #2's lactulose was discontinued on the eMAR but was ordered to be continued on the hospital discharge paperwork. -She was aware Resident #2 missed 1 dose of lactulose on 09/08/26 at 8:00pm and 1 dose on 09/09/26 at 8:00am. -The pharmacy sent a new eMAR with lactulose discontinued. -The MA was supposed to report any resident medication changes to her. -The MA did not let her know lactulose was discontinued on the eMAR on 09/08/26. <p>Second interview with a MA on 09/09/26 at 3:45pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's lactulose was discontinued on the eMAR when she returned from the hospital on 09/08/26. -She did not report Resident #2's concerns for the lactulose being discontinued to the RCC because Resident #2 told her she was going to call her provider. -The RCC was responsible to call the provider and clarify any incomplete or questionable orders. -The RCC was responsible to make sure the medications on the eMAR were correct. <p>Interview with the Administrator on 09/10/26 at 12:00pm revealed:</p>	D 344			

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D 344	<p>Continued From page 4</p> <ul style="list-style-type: none"> -The MA was expected to call the RCC about discrepancies of medication orders and for clarification. -The MA informed the RCC mid-morning on 09/08/26 that lactulose was discontinued on Resident #2's eMAR. -She was not sure if the RCC contacted Resident #2's PCP for clarification. -The contracted pharmacy discontinued lactulose on the eMAR. -The RCC was expected to question the pharmacy regarding medication changes. -The RCC should receive all medication orders. -The RCC could approve orders but cannot change orders on eMARs. <p>The facility failed to clarify medication orders with the contracted facility pharmacy after the MA and RCC learned that lactulose was discontinued on the eMAR for Resident #2. This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/10/26 for this violation.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED October 25, 2026.</p>	D 344		