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CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

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{D 000}	Initial Comments The Adult Care Licensure Section and Cleveland County Department of Social Services conducted a follow-up survey on June 16, 2026 through June 17, 2026.	{D 000}	The response in the cited statement of deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with state laws.	
{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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (Resident #2, #3, and #4) related to a medication used to treat infection (#2), stabilize mood (#4), improve sleep (#4), and treat pain (#3). The findings are: 1. Review of Resident #2's current FL2 dated 05/15/26 revealed diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, chronic kidney disease stage 3, dysarthria (neuromotor speech	{D 358}		

Reviewed and acknowledged by *Melissa J. Jones*, 7/16/26.

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{D 358}	Continued From page 1 disorder resulting in reduced speech intelligibility) following cerebral infarction, and metabolic encephalopathy. Review of Resident #2's primary care provider's (PCP) order dated 06/11/26 revealed doxycycline 100mg (used to treat bacterial infections) one tablet twice daily with food for seven days. Review of Resident #2's June 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for doxycycline 100mg one tablet twice daily with food for seven days scheduled at 8:00am and 8:00pm with a start date of 06/12/26 and an end date of 06/18/26.. -The doxycycline 100mg was documented as administered at 8:00am and 8:00pm from 06/12/26-06/16/26. Observation of Resident #2's medications on hand on 06/17/26 at 9:27am revealed: -There was one bubble pack of doxycycline 100mg with two tablets remaining labeled as "AM" with a dispense date of 06/11/26. -There was a second bubble pack of doxycycline 100mg tablets with four tablets remaining labeled as "PM" with a dispense date of 06/11/26. Review of Resident #2's home health visit note dated 06/12/26 revealed: -There were three wounds on Resident #2's legs. -There was a left mid pretibial trauma full thickness wound measuring 0.8 x 0.6 x 0.1 cm with moderate purulent exudate (a thick opaque fluid that oozes from wounds and is a strong indicator of active bacterial infection). -There was a distal right mid pretibial trauma full thickness wound measuring 3.5 x 1.5 x 0.1 cm with moderate purulent exudate and faint odor.	{D 358}	Medication staff, including Medication Aides and the Resident Care Coordinator, completed comprehensive re-education conducted by the facility Registered Nurse. Training included medication administration requirements under 10A NCAC 13F .1004, proper medication order processing and implementation, pharmacy cycle fill review, medication cart audits, medication availability verification, timely medication reordering, medication error prevention and reporting, physician notification requirements, and development of effective medication administration practices to ensure medications are available and administered as ordered. Medication staff have been in-serviced on immediately notifying the Resident Care Coordinator and/or Executive Director whenever a medication is unavailable or cannot be obtained prior to the next scheduled dose so appropriate follow-up with the pharmacy and prescribing practitioner can occur without delay. The Resident Care Coordinator and/or Executive Director will conduct weekly medication cart & eMAR audits for 60 days. Audits will include verification that medications are available for administration, refill requests have been initiated timely, pharmacy deliveries have been received, and physician notifications have been completed when indicated. Any deficient findings will be corrected immediately, with additional education, competency validation, and corrective action implemented as warranted. The Executive Director will review medication errors, unavailable medications, and pharmacy-related concerns with the Resident Care Coordinator as they occur to ensure timely resolution and prevent recurrence.	7/18/2026 7/18/2026 7/18/2026 7/18/2026

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{D 358}	Continued From page 2 -There was a mid calf right skin tear measuring 8 x 7 x 0.2 cm with a large purulent exudate and faint odor. Interview with Resident #2 on 06/17/26 at 10:05am revealed: -He had wounds on his legs. -He went to a local wound care center weekly for wound treatment. -A home health nurse visited him three times a week to change the dressings on his legs. -He knew he had a recent order for antibiotic treatment. -He could not identify what medications the MAs administered to him. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/17/26 at 10:25am revealed: -They received an order for Resident #2 for doxycycline 100mg one tablet twice daily with food for seven days on 06/11/26. -They dispensed 14 doxycycline 100mg tablets for Resident #2 on 06/11/26. -The doxycycline 100mg was to be started on 06/12/26 at 8:00am and end on 06/18/26 at 8:00pm. Interview with the Resident Care Coordinator (RCC) on 06/17/26 at 10:15am revealed the home health Registered Nurse (RN) visited Resident #2 to change the dressings on his legs today (06/17/26). Telephone interview with the home health Registered Nurse (RN) on 06/17/26 at 11:00am revealed: -She visited Resident #2 that morning (06/17/26) to perform dressing changes on the wounds on the resident's legs..	{D 358}		

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{D 358}	Continued From page 3 -Resident #2's primary care provider (PCP) ordered the doxycycline on 06/11/26 because the resident's legs were "red and weeping". -Resident #2 currently had orders for three dressing changes a week to his legs. -Resident #2 was also being treated weekly at a local wound management center and was last seen there on 06/15/26. -His leg wounds were "worse." -Resident #2's legs were very swollen. -Resident #2 had now developed another wound on his right foot from swelling. Telephone interview with Resident #2's PCP on 06/17/26 at 11:26am revealed: -She ordered doxycycline for Resident #2 on 06/11/26 to treat cellulitis (a common skin infection that can cause redness, swelling, and warmth). -She was present when the home health RN was changing Resident #2's dressings on the wounds on his legs on 06/11/26. -She noticed an "acute" change in his wounds and ordered the doxycycline because she knew it would be several days before Resident #2 would be seen by the local wound care center. -Home Health and the local wound care center normally managed wound treatment. -Resident #2's wounds had an "odor." -The healing of Resident #2's wounds was not "moving in the right direction." -Missing doses of the doxycycline could lead to "less than therapeutic results" and could result in having to repeat antibiotic treatment. -Cellulitis infection could lead to sepsis (a life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs) if not properly treated. Telephone interview with a RN on 06/17/26 at	{D 358}		

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{D 358}	Continued From page 4 11:45am at the local wound care center which provided wound treatment to Resident #2's on 06/15/26 revealed: -Resident #2's should receive the full course of doxycycline for the infection in the wounds on his legs. -Skin infections could develop resistance to antibiotics (occurs when bacteria change so that antibiotic medicines cannot kill them or stop their growth) if a full course of antibiotics was not administered as ordered. Interview with a medication aide (MA) on 06/17/26 at 10:50am revealed: -She documented administering Resident #2's doxycycline on 06/12/26 at 8:00am, 06/13/26 at 8:00am, and on 06/16/26 at 8:00am. -Resident #2 did not refuse medications. -She knew Resident #2 received the doxycycline when she worked. -There were too many doxycycline 100mg tablets left on the AM bubble pack because she "probably" pulled the 8:00am doses she administered from the PM dose bubble pack. Telephone interview with a second MA on 06/17/26 at 2:33pm revealed: -She documented administering Resident #2's doxycycline on 06/12/26 at 8:00pm, 06/14/26 at 8:00pm, 06/15/26 at 8:00pm, and 06/16/26 at 8:00pm. -She "could" have used doxycycline 100mg tablets from the AM bubble pack for the 8:00pm scheduled doses she administered. -She knew she administered the doxycycline to Resident #2. Interview with the Resident Care Coordinator (RCC) on 06/17/26 at 3:40pm revealed: -She documented administering Resident #2's	{D 358}		

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{D 358}	Continued From page 5 doxycycline on 06/13/26 at 8:00pm, 06/14/26 at 8:00am, and 06/15/26 at 8:00am. -If she documented the administration of the doxycycline 100mg then she administered the medication to Resident #2. Interview with the Administrator on 06/17/26 at 12:25pm revealed: -She expected the MAs to follow the prescribers' orders and administer medications as directed. -She audited the medication carts "weekly." -Her last medication audit was on 06/12/26. -In this case, the medication audit would not have picked up on the two missed doses of doxycycline not being administered. 2. Review of Resident #4's current FL2 dated 01/13/26 revealed diagnoses included chronic obstructive pulmonary disease, unspecified urinary incontinence, and abnormal weight loss.	{D 358}		
	Review of Resident #4's signed primary care provider's (PCP) order dated 05/13/26 revealed quetiapine (used to stabilize mood) 100mg one tablet by mouth at bedtime. Review of Resident #4's May 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for quetiapine 100mg one tablet by mouth at bedtime scheduled at 8:00pm with a start date of 05/13/26. -Quetiapine 100mg was documented as administered at 8:00pm from 05/13/26 through 05/31/26. Review of Resident #4's June 2026 eMAR revealed: -There was an entry for quetiapine 100mg one tablet daily one tablet by mouth at bedtime.			

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{D 358}	Continued From page 6 -The quetiapine was documented as administered at 8:00pm from 06/01/26 through 06/15/26. Observation of Resident #4's medication on hand on 06/16/26 at 4:20pm revealed quetiapine 100mg was not available on the medication cart. Interview with Resident #4 on 06/16/26 at 9:36am revealed: -She was out of quetiapine. -She had been out of the quetiapine for five days. -The quetiapine helped with her mood and sleep. -A medication aide (MA) told her she would reorder it from the pharmacy on Monday (06/15/26). -The MAs were supposed to reorder her medications before she ran out. -She called her physician's office "this morning" (06/16/26). -The physician's office staff told her they did not know she was out of quetiapine. -She had been irritable and has not slept at night due to missed doses of quetiapine. Interview with Resident #4 on 06/17/26 at 10:08am revealed she had been irritable and has not slept at night due to missed doses of quetiapine. Telephone Interview with the facility's contracted pharmacist on 06/17/26 at 10:19am revealed: -The pharmacy had an active order dated 05/13/26 for quetiapine 100mg, one tablet by mouth at bedtime. -Quetiapine 100mg was last dispensed on 06/08/26 with a quantity of two tablets due to the pharmacy needing a new prescription. -The pharmacy notified the facility that a new prescription was needed but did not receive one.	{D 358}		

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{D 358}	Continued From page 7 -Resident #4 did not have quetiapine available for administration from 06/12/26 through 06/15/26. -Resident #4 could have difficulty sleeping, experience agitation, gastrointestinal upset and irritability. Telephone interview with a Licensed Practical Nurse (LPN) with Resident #4's PCP office on 06/17/26 at 3:07pm revealed the facility did not notify the PCP office of the resident not having of her quetiapine until yesterday (06/16/26) when the facility requested a prescription for Resident #4's quetiapine. Telephone interview with a MA on 06/17/26 at 4:50pm revealed: -She did not know Resident #4 had not received her ordered dose of 100mg of quetiapine. -MAs were responsible for verifying medication on the eMAR with medications on the medication cart before administering to the residents. -If a medication was missing, the MAs were responsible for notifying the RCC. -The MAs or the RCC were responsible for re-ordering resident medications. Interview with Resident Care Coordinator (RCC) on 06/17/26 at 4:25 revealed: -She did not know Resident #4 had not received quetiapine since 06/12/26. -The MA should let the RCC or Administrator know if they were out of a medication. -She or the MAs were responsible for re-ordering resident medications. Interview with the Administrator on 06/17/26 at 4:30 revealed: -The MAs were responsible for notifying the RCC or herself know if they were out of a medication.	{D 358}		

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{D 358}	Continued From page 8 -She did not know Resident #4 had not received quetiapine since 06/12/26. -The MAs or the RCC were responsible for re-ordering resident medications. -She had completed a medication cart audit one day last week and the medication was there. 3. Review of Resident #3's current FL2 dated 06/05/26 revealed diagnoses included epilepsy, gastro esophageal reflux disease, altered mental status, Wernicke's encephalopathy (a serious, acute neurological disorder caused by severe vitamin B1 deficiency), and anxiety disorder. Review of Resident #3's Resident Register revealed an admission date of 10/20/25. Review of Resident #3's Primary Care Provider's (PCP) order dated 02/13/26 revealed there was an order for cyclobenzaprine (used to treat muscle spasms and associated pain) 5mg twice daily as needed. Review of Resident #3's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for cyclobenzaprine 5mg twice daily as needed. -Resident #3 was administered cyclobenzaprine 28 times from 05/01/26 to 05/15/26, 05/17/26, 05/20/26 to 05/27/26, 05/24/26 to 05/25/26, and 05/27/26. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for cyclobenzaprine 5mg twice daily as needed. -On 06/02/26 through 06/04/26, cyclobenzaprine was administered daily. -There was no other documentation of administration for the rest of the month.	{D 358}		

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{D 358}	Continued From page 9 Observation of Resident #3's medication on hand on 06/16/26 at 4:20pm revealed there was no cyclobenzaprine available on hand. Interview with Resident #3 on 06/16/26 at 9:33am and on 06/17/26 at 8:36am revealed: -The facility was out of her muscle relaxant medication. -She had been without the muscle relaxant medication for "five or six days". -She last got her cyclobenzaprine at the first of the month of June 2026 but could not remember the exact date. -She had been asking the medication aide (MA) for the medication every day at first, then every other day and eventually gave up. -She had asked for the medication again last night (06/16/26) but was unable to get it. -She took the muscle relaxant for "neck pain" and without the medication she was "more sore than normal". -She also had difficulty sleeping when she was in pain. -She started having issues with receiving the medication near the beginning of this month (June 2026). -A medication aide (MA) told her a refill request was sent to the pharmacy. -The pharmacy might need a new prescription to refill the medication. Telephone interview with the facility's contracted pharmacist on 06/17/26 at 10:19am revealed: -The pharmacy had an active order for cyclobenzaprine 5mg twice daily as needed. -Cyclobenzaprine 5mg was dispensed on 02/24/26 for 30 tablets. -Cyclobenzaprine 5mg was dispensed on 04/10/26 for 30 tablets.	{D 358}		

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{D 358}	Continued From page 10 -Cyclobenzaprine 5mg was dispensed on 04/25/26 for 30 tablets. -Cyclobenzaprine 5mg was last dispensed on 05/08/26 for 30 tablets. -She had not received any refill requests in the month of June for cyclobenzaprine until yesterday (06/16/26). -If Resident #3 needed cyclobenzaprine and she was not given it, it could cause continued symptoms such as muscle pain and stiffness, which could affect sleep if she was in pain. Telephone interview with Resident #3's PCP on 06/17/26 at 9:09am revealed: -The facility sent a request to her yesterday (06/16/26) about refilling Resident #3's cyclobenzaprine. -She did not know the facility did not have cyclobenzaprine available to administer. -She had last seen Resident #3 on 06/12/26. -Resident #3 told her on 06/12/26 that she needed cyclobenzaprine, but the facility had not mentioned it to her. -The facility should have been able to request a refill when the medication ran out. -If there had been an issue with the medication from the pharmacy, they would have contacted her, and the pharmacy never contacted her about that medication. -If Resident #3 did not receive her cyclobenzaprine, she could have continued pain and muscle spasms, but she was prescribed alternative pain medications she could ask for. Interview with a MA on 06/17/26 at 12:04pm revealed: -Resident #3 had asked her for cyclobenzaprine near the first of June 2026, but she could not get the order filled due to it being too soon to fill. -She had checked on refilling it on 06/01/26 and	{D 358}		

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{D 358}	Continued From page 11 around 06/05/26, and the pharmacy told her it was too early to get a refill. -She ordered refill requests on the computer and then would call the pharmacy to follow up to make sure they received the refill request. -Resident #3 asked her a couple times for the medication since she last received it on 06/04/26, but she never complained of pain to her. Interview with the Resident Care Coordinator (RCC) on 06/17/26 at 3:02pm revealed: -She ordered refill requests on the computer and would call the pharmacy to make sure they received the request. -She had not requested any refills for Resident #3's cyclobenzaprine. -She did not realize Resident #3 was out of cyclobenzaprine. -Resident #3 did not tell her she needed cyclobenzaprine. -She helped audit medication carts weekly but did not audit the medication cart Resident #3's medications were stored in for the month of June. Interview with the Administrator on 06/17/26 at 9:56am revealed: -She last audited the medication cart and noticed cyclobenzaprine was not available to administer on 06/06/26. -She thought the MA sent a refill request on 06/06/26. -On 06/12/26, she did another audit and missed that medication because she had it confused with another medication that had a similar name and she thought it was on the cart. -She did not realize Resident #3's cyclobenzaprine never came. -She tried to order Resident #3's cyclobenzaprine from the back up pharmacy yesterday (06/16/26) and she tried to pick it up at 7:15pm last night and	{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 the backup pharmacy was closed. -The MAs and RCC were responsible for getting the medications refilled. -It was her responsibility to check behind the MAs and RCC. The facility failed to administer medications as ordered for 3 of 5 sampled residents. Resident #2 had an order for doxycycline and he did not receive the full course of antibiotics as ordered increasing the resident's risk of having to repeat antibiotic therapy, development of sepsis and antibiotic resistance. The facility also failed to administer quetiapine for five days to Resident #4 which resulted in mood and sleep changes. Resident #3's cyclobenzaprine not being available for administration since 06/04/26 which resulted in muscle spasms and pain in the neck and shoulders, which affected her sleep. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 06/17/26.	{D 358}		